Case Number **528A5 IR20190506-000079**

DEPARTMENT OF VETERANS AFFAIRS POLICE
528A5 - CANANDAIGUA VAMC
400 FORT HILL AVENUE
CANANDAIGUA, NY, 14424

Incident Report

Reported by: **WHITE, DARRYL J**

Incident Types Label	Offender	Incident Disposition
INCIDENTS : 90Z - OTHER OFFENSES : PHARMACY / MEDICATIONS : NON-CONTROLLED SUBSTANCE : THEFT / STOLEN	**, (SUSPECT)**	**CLOSED**

Report Disposition	Method of Reporting
CLOSED	**PHONE**

Report Recorder	Manager/Supervisor On Duty	Manager/Supervisor Notified
WHITE, DARRYL J	**STREGE, KENT**	**YES**

Incident Occurred Date	Incident Occurred End Date	Incident Discovered / Called In
05/02/2019 at 0001	**05/05/2019 at 1730**	**05/05/2019 at 1700**

Location	Specific Location
CANANDAIGUA VA MEDICAL CENTER : OTHER	**BLDG 8 ROOM 237**

Report Synopsis/Overview

The night Patient Care Coordinator (PCC) contacted VA Police regarding missing Lidocaine patches 5% from building 8 room 237. The patches were in a filing cabinet connected to the office and the filing cabinet does not have a lock on it. This is an open investigation.

Contact # 1 (VICTIM)

Full Name

(b) (6), (b) (7)(C)

Drivers License	Drivers LicenseState	Email Address
(b) (6), (b) (7)(C)		

Department	Title
NURSING SERVICE	**NURSING SUPERVISOR**

Notes

PCC NURSING SUPERVISOR

Addresses

Street Number	Street Direction	Street Name	Street Type	Apt./Suite	Address Type
(b) (6), (b) (7)(C)					**HOME**

Prepared By:	Submitted Date
WHITE, DARRYL J(DARRYL.WHITE2@VA.GOV)	05/06/2019 1823

Signature	Reviewed By/Date

Case Number 528A5 IR20190506-000079

Phones :

(b) (6), (b) (7)(C)

Contact # 2 (SUSPECT)

Theft

NCIC/State ID #:	What was stolen? (overview)	Stolen Items Value
	10 - LIDOCAINE PATCHES 5%	**$83.30**
Subject"s Name:	Officer Witness	Retail Theft?
		NO

Narrative text

On 05/05/2019 at approximately 5:00pm VA Police Officer Darryl White Badge # 5267 received a call from Dispatch from Victim (V) (b) (6), (b) (7) – Patient Care Coordinator, Registered Nurse to report missing Lidocaine patches 5% from (filing cabinet drawer. The Lidocaine patches are (b) (6), (b) (7)(C). (V) (b) stated that she left work Wednesday, May 1, 2019 after her shift ended at 12 midnight for the weekend and when she returned on Sunday, May 5, 2019 at approximately 7:45am is when she noticed that about 10 Lidocaine patches of 5% were missing from (b) prescription boxes. The prescription box had 8 Lidocaine Patches 5% left in the box when (V) (b) looked to use a patch Sunday, May 5, 2109. (V) (b) informed Officer White that the prescript box was missing approx. 10 patches.

I have obtained (V) (b) (6), statement of the incident and will request a list of Employees that were working between the hours stated above. The PCC's are managed by Shannon Cicero -Infection Preventionist.

June 26,2019
This case will be closed out due to unsolvable factors.

Prepared By:	Submitted Date
WHITE, DARRYL J(DARRYL.WHITE2@VA.GOV)	05/06/2019 1823
Signature	**Reviewed By/Date**

Department of Veterans Affairs
VA Police
Bath
Investigative Report
Investigative Report#: 2018-05-23-1130-5876

VA Facility: Bath **Date/Time Printed** 5/24/2018 15:18

This Document is to be handled in accordance with the Privacy Act

Contents shall not be disclosed, discussed, or shared with individuals unless they have a direct need-to-know in the performance of their official duties. The document(s) are to be handled in accordance with For Official Use Only procedures.

Date/Time Received	5/23/18 11:30 AM
Date/Time of Offense:	5/22/18 22:40 PM
Location:	BLDG. 78 CLC-1
Investigating Officer	JOHN KUNAK
Incident Synopsis:	Discrepancy found in patients Med tray involving two doses of Morphine.
Classification Code:	Non-Criminal Information(F)
Final Disposition:	**Case Closed**
Initial Disposition:	Initial Investigation Completed
Case Status:	CLOSED

Use of Force

OC Weapon used:	No
Baton Used:	No
Firearm Drawn:	No
Firearm Used:	No

Complainant

Name:	UNITED STATES GOVERNMENT
Status:	
Work Address	N/A N/A N/A, US
Work Phone	
Statement	

Name:	Jerri L Ritter
Status:	Employee - Clinical
Work Address	DVAMC, CLC-1 76 Veterans Ave Bath, NY 14810
Work Phone	6076644000
Statement	

Victim

Name:	UNITED STATES GOVERNMENT		
Gender:		**Ethnicity:**	
Status:			
Driver's License:		**State:**	GENERAL
Work Address:	N/A N/A N/A, US		
Work Phone:			
Treatment:	No		

Facility: Bath IR#: 2018-05-23-1130-5876

Suspect

Name: (b) (6), (b) (7)(C)
SSN:
Gender:
Weight:
Skin Tone
Status:
Driver's License Number: **License State:** GN
Home Address: (b) (6), (b) (7)(C)
Home Phone:
Work Address:
Work Phone:
Offense(s): Non-Criminal: Information(F)
Violation(s):

Notification

Agency:	OIG
Contact:	S/A Jeffrey Stachowiak
Date & Time of Notification:	5/23/18 1258
Instructions Received:	Briefed on incident, will update as investigation continues.

Narrative

Origin

Briefed by LT JOSEPH RACALTO and Officer RICHARD MEDON regarding a call they responded to on CLC-1 at approx. 2340 hrs. May 22, 2018.

CLC-1 staff contacted VA Police reporting that they found a discrepancy in a patients Med tray. Although the patient received the correct number of doses they found two more dosages of morphine than they should have in the med tray.

Investigation

It was learned that the med cart was replenished the day before by Pharmacy. Upon receiving the information, I contacted Pharmacy Manager DAVID MOYER, he will check the med cart/pyxis machine and will notify RN Director MICHELLE SANTOS.

This investigator notified/briefed VA Police Chief JOSEPH DAY and S/A Jeffrey Stachowiak, Office of the OIG of the reported incident.

Investigation continued with myself and Pharmacy Manager DAVID MOYER interviewing the evening nurses that reported the discrepancy. Spoke with charge RN JERRI RITTER, who stated that she reported the incident to her superiors (KATIE ROOTE, MICHELLE SANTOS) she also stated that the nurse that created the discrepancy (b) (6), (b) works the day shift.

Pharmacy manager DAVID MOYER stated that he will conduct an inventory of the pyxis/med cart to insure accountability of it's contents.

On Thursday May 24, 2018, I met with nurse (b) (6), (b), conducted an interview regarding the two vials of morphine in found in the med cart tray.
Upon completion of the interview nurse (b) (6), (b) provided me with the following information in a Voluntary hand written statement.

In brief, (b) stated she was working the day shift on 5-22-18, around 0930 hrs.she removed two 10mg/0.5 ml syringes to give to a patient for their 1100 doses (b) stated when she later went to give the patient his medications, she went into the pyxis and took out two more vials forgetting that she had already taken the two vials out earlier. (b) stated that she didn"t realize this occurred until it was found by another shift and reported to the supervisor. For details refer to statement.

Investigation revealed:

There was no theft of the morphine being reported by the staff. The reason the VA Police were notified was to report that they found two vials of morphine in the lock med tray of the pyxis machine.

As the investigation continued it was learned that a total of four vials of morphine had been scanned and removed from the pyxis machine for the same patient. A review of the patients records for the times/dates of the doses were checked. The records indicated that the patient received the two doses he was intended to receive. The remaining two vials were still in tact, scanned, and remained in the locked med tray.

The two vials of morphine were removed from the med tray, bagged and placed in a locked cabinet in the medication
room.

The morning of Thursday May 24, 2018, SHELIA DARCY, (Pharmacy) sent two pharmacy staff member over to inventory the pyxis and added the 2 vials of morphine back into the pyxis machine.

Refer to attached Detail of Pyxis Discrepancy form for details.

Investigation reveals no Criminal intent was committed, therefore no criminal charges are warranted at this time.

However Human error appears to be the big factor as admitted by (b) (6), (b) (7) who admitted that she was trying to make things easier for her rounds(taking a short cut) and in doing so forgot that she had already removed the medication from the pyxis machine.

This incident could have very easily avoid if the proper procedure were followed, not to mention that it could have turned into a whole new investigation had the patient been given an additional dose of medication.

Since no criminal charges are warranted, this investigation will be closed at this time. The investigation will be forwarded to Nurse Executive manager for review/further action.

Contacted S/A JEFFREY STACHOWIAK and S/A CHRIS BARLOW, Office of the OIG, briefed them on the outcome of the investigation. Will scan/e-mail report.

Investigating Officer:	JOHN KUNAK	**Signature:**	John Kunak
Badge:	1302-DN	**Date:**	5/24/18
Printed by:	JOHN KUNAK		

< < < End of Report > > >

Detail of Pyxis Discrepancy

Location: CLC-1

Date & Time: 5/24/18

Patient: N/A (Inventory of drawer)

Drug: Morphine 10mg/0.5mL

Count prior to discrepancy: 39

Count after discrepancy: 41

Staff Involved (b) (6), (b) (7)(C) / (b) (6), (b) (7)(C)

(b) (6), (b) (7)(C)

Detailed explanation of what Occurred: ~~on~~ 5/20/18 2 morphine ~~10~~mg/0.5mL removed from Pyxis, locked in med cart to be given in 20 min when it could be ~~given~~ scanned (1° prior to sched. time) an given. Morphine was forgotten & stayed locked in drawer (sealed in original packaging) until discovered on Evening & locked in med room cabinet. These are being returned to inventory @ this time ~~when~~ @ this time 2 RN's are ~~in error~~ doing inventory of drawer

Action taken to resolve discrepancy: ~~discrepancy~~ and adding these 2 morphined back to drawer, creating & then clearing a discrepancy as per instruction from Sheila Darcy

Signatures (b) (6), (b) (7)(C) (b) (6), (b) (7)(C)

NURSE MANAGER:

FAX TO THE PHARMACY AT ext. 44461-on station

Department of Veterans Affairs

VOLUNTARY WITNESS STATEMENT

Location: Bld 78 CLC-1 Date: 5/24/18

I (b) (6), (b) (7)(C), residing at or employed at Bath VAMC,
make the following statement freely and voluntarily:

I was asked by detective Kunak what information/ knowledge I have conserning the two ~~of~~ vials of morphine that were found in the med cart. on the Evening shift: On the day shift on 5/22/18 around 0930 I removed 2- 10mg/0.5mL Syringes for an 1100 (b) (6), (b) (7)(C) scheduled dose of morphine for (b) (6), (b) (7)(C) intending to scan & give @ 1000. I placed the morphine in his drawer in the medication cart & locked it. I forgot that I had taken these out & they remained in his drawer throughout the remainder of that shift & part of evening shift until (b) (6), (b) (7)(C) they were discovered. At 1115 that morning I went back into the pyxis & took out 2 more syringes, scanned these & the pt. & administered his scheduled 1100 dose.

(b) (6), (b) (7)(C) per report from other shifts & Supervisor When these were found on the evening tour, they looked @ the administration record & saw that veteran (b) (6), (b) (7)(C) morphine had been scanned, but saw the syringes as well and were unsure if he had recieved the medication

(b) (6), (b) (7)(C) (Initials)

VA FORM JAN 1993 (R) 0024

Adobe Forms Designer 6.0

Department of Veterans Affairs

VOLUNTARY WITNESS STATEMENT *(Continuation Sheet)*

Statement of

That had been scanned as given.

5/23/18 I spoke w Shela Darcy at the start of the day tour. She states that it shows in the pyxis where ~~2 vials were removed around 9:30 & 2 more were removed around 11:30~~ (b) (6), (b) (7)(C) error & 4 vials had been removed & 2 were given. Shela was concerned where the other 2 vials were and I assured her that they were bagged & initialed - sealed and locked in the cabinet in the medication room, in their original packaging.

5/24/18 I spoke w Shela Darcy and she states for two licenced staff to inventory drawer & add the 2 vials of morphine back in. that are still locked & bagged in cabinet. Myself & Gretchen Deen RN returned these/ see "Detail of pyxis Discrepancy" form attatched

I have read/have had read to me the above statement consisting of 2 page(s), and certify that it is true and correct to the best of my knowledge.

No threats or promises have been made to me and no pressure or coercion of any kind has been used against me.

(b) (6), (b) (7)(C)

(Declarant) Signature

5/24/18
(Date)

Det John Kunak
(Witness) Signature

5-24-18
(Date)

VA FORM JAN 1993 (R) **0024**

Adobe Forms Designer 6.0

INTERVIEW / INTERROGATION LOG

UOR # _____ DATE: _____

NAME: (LAST, FIRST, MIDDLE)	SSN# (b) (6), (b) (7)(C)
(b) (6), (b) (7)(C)	

INTERVIEW LOCATION	TIME/DATE
Bldg 78 CLC-1	1110 5-24-18
QUESTIONS PRIOR TO WARNING (IF ANY)	TIME/DATE
CONSTITUTIONAL RIGHTS GIVEN USING VA FORM 10-1430 AND/OR 0023:	TIME/DATE
WEINGARTEN RIGHTS GIVEN:	TIME/DATE
WAIVER SIGNED YES NO	TIME/DATE

OTHERS PRESENT (FULLNAME, PHONE NUMBER AND AGENCY)

1. _____

2. _____

INTERVIEWER NAME AND SIGNATURE

Det John Kunak

Case Number [redacted]

DEPARTMENT OF VETERANS AFFAIRS POLICE
528 - BUFFALO VAMC
3495 BAILEY AVENUE
BUFFALO, NY, 14215

Incident Report

Reported by: **HEINZ, LAWRENCE**

Incident Type(s) Label	Offender	Incident Disposition
INCIDENTS : 23A-23H LARCENY/THEFT OFFENSES : 23H ALL OTHER LARCENY/THEFT : PHARMACY CONTROLLED SUBSTANCE - THEFT (PETTY MISDEMEANOR)	**UNKNOWN, PERSON(S) (SUSPECT)**	**REFERRED TO ADMIN**

Report Disposition	Method of Reporting	
PENDING INVESTIGATION	**POLICE SERVICE: WALK-IN**	
Report Recorded By	**Manager/Supervisor Notified**	
HEINZ, LAWRENCE	**YES**	
Incident Occurred Date	**Incident Occurred End Date**	**Incident Discovered / Called In**
09/26/2018 at 1616	**09/26/2018 at 1625**	**09/26/2018 at 1630**
Location	**Specific Location**	
WESTERN NEW YORK HCS : BUFFALO VA MEDICAL CENTER : OTHER	**OUTPATIENT ENTRANCE FOYER/ OUTPATIENT PHARMACY WAITING AREA**	

Report Synopsis/Overview

Report of Theft of Narcotic prescription(Oxycodone) from patient's personal belonging bag.

Contact # 1 (REPORTING PERSON)

Full Name

(b) (6), (b) (7)(C)

[redacted]

Department	Title
OTHER	**VETERAN PATIENT**

Addresses

Street Number	Street Direction	Street Name	Street Type	Apt/Suite #
(b) (6), (b) (7)(C) [redacted]			**ROAD**	

Country	Address Type
	HOME

Phones :

(b) (6), (b) (7)(C) [redacted]

Prepared By	Submitted Date
HEINZ, LAWRENCE(LAWRENCE.HEINZ@VA.GOV)	
Signature	**Reviewed By/Date**

Case Number [redacted]

Contact # 2 (VICTIM)

Full Name

(b) (6), (b) (7)(C)

[redacted]

Department
OTHER

Title
VETERAN PATIENT

Addresses

Street Number	Street Direction	Street Name	Street Type	Apt/Suite
(b) (6), (b) (7)(C) [redacted]			ROAD	

Address Type
HOME

Phones :

(b) (6), (b) (7)(C)

Contact # 3 (SUSPECT)

Full Name
PERSON(S) UNKNOWN

Age	Date of Birth	Gender	Race
		FEMALE	HISPANIC

Height	Weight	Hair Color	Eye Color
5'03"		BLACK	

Approx. Age	Demeanor	Build	Clothing
25-34		SHORT	UNKNOWN CLOTHING

Department	Title
OTHER	UNKNOWN OFFENDER

Notes
VICTIM COULD NOT OBTAIN A DESCRIPTION OF OFFENDER AS OFFENDER WAS BEHIND HIS WHEELCHAIR AT THE TIME OF INCIDENT.

Property #1 (STOLEN)

Property Reference #	Property Type	Property Category
	10 DRUGS/NARCOTICS	STOLEN

Property Disposition	Barcode Number
STOLEN	100000024282

Property Description	Property Location
OXYCODONE PILLS	

Prepared By
HEINZ, LAWRENCE(LAWRENCE.HEINZ@VA.GOV)

Submitted Date

Signature

Reviewed By Date

Case Number [redacted]

Approximate Size	Property Color	Owner
5 MG TABLETS	WHITE	(b) (6), (b) (7)
Approximate Value	**Quantity**	**Total**
$100.00	20	$2,000.00

Theft

NCIC/State ID	What was Stolen/Lost/Seized	Stolen Items Value
	OXYCODONE TABLETS	$100.00
Subject's Name	**Officer's Witness**	**Recovered Theft?**
UNKNOWN, PERSON(S)		NO

Narrative text

At 1630 hrs. 26 September 2018, (b) notified police(Heinz) at the police sub-station of this incident. Investigation by police revealed at 1616 hrs. 26 September 2018 at the Outpatient Pharmacy (b) who was in a wheelchair, picked up his medication prescription and after picking up his medication and placing it in a paper bag he was approached by an unknown Hispanic female(5-03 tall, short brown hair, freckled complexion about 30 yrs. old) offering him assistance to wheel him to his car outside the Outpatient Entrance. After giving this unknown Hispanic female permission to assist him, the unknown Hispanic female took (b) (6), bag containing his medication and personal items and placed it on the hook on the wheelchair and proceeded to transport (b) to the Outpatient Entrance. Upon arrival to the Outpatient Entrance, (b) made a check of the bag containing the personal items and medications and found that the bottle containing 20 5mg. Oxycodone tablets valued at or about $100.00 were missing as well as the unknown Hispanic female who fled/departed the scene.

A check of the Outpatient Entrance area by (b) & police met with negative findings as the offender is at large with charges pending. A further check by [redacted] revealed that there was nothing else in his bag that was missing/stolen in this incident.

(b) upon completing this report, contacted his primary care provider and notified him of this incident. The primary care provider re-wrote the prescription for the Oxycodone and would have it mailed to (b) (6), home address.

This case remains open pending a check of the camera system of the Pharmacy area and Outpatient Entrance foyer as to if this offender can be identified at this time. Chief Steinmetz was ntfd at 1720 hrs.

Prepared By	Submitted Date
HEINZ, LAWRENCE(LAWRENCE.HEINZ@VA.GOV)	
Signature	**Reviewed By/Date**

Dispensing Data 09/26/2018 04:16 PM SJS

Scripts

Script #	Patient Name	Drug Name	Qty	Third Party
14484...	(b) (6), (b) [redacted]	Acetaminophen Mapap 325 mg Tab Ma...	80	
19326...	(b) (6), (b) [redacted]	Oxycodone HCL 5 mg Tab GSMS	20	

Dispensing Certification NCPDP

Signature (b) (6), (b) (7)(C) [redacted]

X [redacted]

Counseling Complete

Declined
09/26/2018 04:16 PM

Dispensing Comments

Comment	F	V	D	By
[redacted]				

Ins

Del

Relationship Self

Recipient (b) (6), (b) (7)(C) [redacted]

Print

OK

Cancel

Department of Veterans Affairs

VOLUNTARY WITNESS STATEMENT

Location: VA Police office Date: 9/26/2018

I, (b) (6), (b) (7)(C), residing at or employed at (b) (6), (b) (7)(C)

make the following statement freely and voluntarily:

After leaving the pharmacy window w/ two prescriptions a young Hispanic woman asked to help me w/ my wheel chair. She took the bag from me that held several item in which I had also placed the medications. When I got to the car I checked the bag and found one of the medications missing. The woman was gone w/ the medication and the accompanying paperwork w/ my information. Looking back it seemed she was waiting for me, w/ the hex cast she probably assumed I would be getting pain meds.

Q. About what time did you leave the Pharmacy window?
A. 4:16 PM (b) (6), (b) (7)(C)

Q. Can you give a better discription of the Hispanic woman?
A. short, maybe 5'3", short hair, freckled complection. Brown hair. Aprox 30 years old (b) (6), (b) (7)(C)

Q. Was anything else taken/stolen besides the narcotics?
A. No. (b) (6), (b) (7)(C)

(b) (6), (b) (7)(C)
(Declarant Initials)

VA FORM JAN 1993 0024

Department of Veterans Affairs

VOLUNTARY WITNESS STATEMENT *(Continuation Sheet)*

Statement of (b) (6), (b) (7)(C)

Q. Did you See Which WAY The Woman Went?

A. No I did Not (b) (6), (b) (7)(C)

Q. Is There Any Thing you WISH To Add Further in This Report?

A. NO (b) (6), (b) (7)(C)

I have read/have had read to me the above statement consisting of 2 page(s), and certify that it is true and correct to the best of my knowledge.

No threats or promises have been made to me and no pressure or coercion of any kind has been used against me.

(b) (6), (b) (7)(C)

(Declarant) Signature 9/26/2018 *(Date)*

(Witness) Signature 9/26/2018 *(Date)*

VA FORM JAN 1993 **0024**

Case # : [redacted]

DEPARTMENT OF VETERANS AFFAIRS POLICE
528 - BUFFALO VAMC
3495 BAILEY AVENUE
BUFFALO, NY, 14215

Incident Report

Reported By: **WRIGHT, DAVID**

Incident Type(s) Label	Offender	Incident Disposition
INCIDENTS : 23A-23H LARCENY/THEFT OFFENSES : 23H ALL OTHER LARCENY/THEFT : PHARMACY CONTROLLED SUBSTANCE - THEFT (FELONY)	(b) (6), (b) (7) (SUSPECT)	CLOSED
INCIDENTS : 23A-23H LARCENY/THEFT OFFENSES : 23H ALL OTHER LARCENY/THEFT : PHARMACY CONTROLLED SUBSTANCE - THEFT (FELONY)	(b) (6), (b) (6), (b) (SUSPECT)	UNFOUNDED

Report Disposition	Method of Reporting
CLOSED	VA EMPLOYEE

Incident Occurred Date	Incident Occurred End Date	Incident Discovered / Called In
03/30/2018 at 0948	03/30/2018 at 1330	03/30/2018 at 1230

Location	Specific Location
WESTERN NEW YORK HCS : BUFFALO VA MEDICAL CENTER : PATIENT CARE : PHARMACY	OUTPATIENT PHARMACY

Manager/Supervisor On Duty	Manager/Supervisor Notified
STEINMETZ, MICHAEL	YES

Report Synopsis / Overview

On Friday, March 30, 2018, VA Police Services received a phone call from a VA Outpatient Pharmacist concerning a possible larceny of a veterans controlled prescription medication. VA Police Sergeants made contact with the pharmacist and received all pertinent information and details concerning the incident. VA Chief of Police was informed of the situation and directed reporting Sergeant to forward all gathered information to VA Police Detective for follow up investigation. Initial Investigative Report generated.

List of supplemental reports

Follow Up 528 IR20180331-000216_1

List of contacts in this report

HEIBEL, ANTHONY	REPORTING PERSON
(b) (6), (b) (7)(C)	SUSPECT
(b) (6), (b) (7)	SUSPECT
UNKNOWN NAME	UNKNOWN
(b) (6), (b) (7)	VICTIM
(b) (6), (b) (7)	WITNESS

Contact # 1 (REPORTING PERSON)

Full Name
ANTHONY E HEIBEL

Driver's License # | Driver's License State | Email Address
(b) (6), (b) (7)(C)

Prepared By: WRIGHT, DAVID(DAVID.WRIGHT9@VA.GOV)
Submitted Date: 03/31/2018 1358

Signature
Reviewed By Date

Case # : [redacted]

(b) (6), (b) (7)(C)

[redacted]

Department: MEDICAL SERVICE

Title: PHARMACIST

Addresses

Street Number	Street Direction	Street Name	Street Type	Apt / Suite
3495		BAILEY		

City	State	Zip	Country	Address Type
BUFFALO	NY	14215	USA	WORK

Phones :

(WORK) 7168627972

Contact # 2 (SUSPECT)

Full Name: [redacted]

(b) (6), (b) (7)(C)

[redacted]

Apt / Suite: [redacted]

Address Type: HOME

Phones :

(b) (6), (b) (7)

Contact # 3 (SUSPECT)

Full Name: [redacted]

(b) (6), (b) (7)

Contact # 4 (SUSPECT)

Full Name: [redacted]

(b) (6), (b) (7)(C)

[redacted]

Email Address: [redacted]

Race: [redacted]

Clothing: [redacted]

Prepared By: WRIGHT, DAVID(DAVID.WRIGHT9@VA.GOV)

Submitted Date: 03/31/2018 1358

Signature: [redacted]

Reviewed By Date: [redacted]

Case # : [redacted]

Department	Title
NURSING SERVICE	NURSES AID

Addresses

Street Number	Street Direction	Street Name	Street Type	Apt / Suite	Address Type
(b) (6), (b) (7)(C)					HOME

Phones : (b) (6), (b) (7)(C)

Contact # 5 (UNKNOWN)

Full Name

Contact # 6 (VICTIM)

Full Name (b) (6), (b) (7)(C)

(b) (6), (b) (7)(C)

Addresses

Street Number	Street Direction	Street Name	Street Type	Apt / Suite	Address Type
(b) (6), (b) (7)(C)					HOME

Phones : (b) (6), (b) (7)(C)

Property #1 (STOLEN)

Property Reference #	Property Type	Property Category
	10 DRUGS/NARCOTICS	STOLEN

Property Disposition	Barcode Number
STOLEN	100000024226

Property Description	Property Location
PRESCRIPTION NARCOTIC	

Brand	Model	Serial Number
OXYCODONE		

Approximate Size	Property Color	Owner
5MG	WHITE	

Prepared By	Submitted Date
WRIGHT, DAVID(DAVID.WRIGHT9@VA.GOV)	03/31/2018 1358

Signature | Reviewed By/Date

Case # : [redacted]

Approximate Value	Quantity	Total
$5.00	9	$45.00

Narrative text

On Friday, March 30, 2018 at approximately 1230 hours, Police Sergeant D. Wright received a phone call from Outpatient Pharmacy Pharmacist Anthony "Tony" Heibel with information concerning the possible theft of a veterans controlled prescription medication.

Sergeant Wright, along with Police Sergeant J. Borkowski responded to the pharmacy to meet with Mr. Heibel. Mr. Heibel stated that he had received information from the Health Response Center, a software information reporting system, that a veteran who had been discharged the day prior was short 9 of his prescribed 30 pills in his sealed prescription bottle.

Mr. Heibel stated that Pharmacist Natalie Cipolla and Pharmacy Technician Nick D'Agnostino were handling the 5mg.tablet Oxycodone prescription at the time, and no issues were apparent when it was picked up by patient (b) (6), (b) (7)(C). Mr. Heibel notified Pharmacy Chief Nancy Fucilli of the situation and an inventory was immediately conducted showing no immediate discrepancies in the inventory levels within the pharmacy vault.

According to Mr. Heibel, he spoke with (b) [redacted], the spouse of Patient (b) [redacted] ,and realized something was wrong when they got home and opened the clear plastic bag which contained the prescription bottle and found a loose tablet within the bag. Mr. Heibel informed police that standard pharmacy procedure is to seal the bottle with a piece of red tape as an additional protective measure. He claimed it to be very unlikely that a tablet would have made its way into the plastic bag without someone actually opening the bag, removing the tape, and opening the bottle. (b) (6), (b) stated to Mr. Heibel that neither she nor her husband [redacted] had opened the bottle prior to returning home from the hospital.

Further police questioning revealed that Mr. Heibel spoke with Nurse Manager William Walkden on 8D and informed him that (b) [redacted] was transported from 8D to the pharmacy by a volunteer by the name of (b) [redacted]. The volunteer then transported (b) (6), [redacted] back to his room to gather his personal items and prepare for his discharge.

When asked by police if he wanted to add any additional information, Mr. Heibel stated that he attempted to contact OIG Agent Chris Barlow concerning this incident, but was unable to make contact with him. When asked by Sergeant Borkowski as to why he would contact Agent Barlow first, he claimed that it was past practice to contact OIG since most missing prescription incidents happen off of property as opposed to "in house".

Mr. Heibel was instructed to complete a Report of Contact and to notify Ms. Cipolla and Mr. D'Agostino to complete the same , to which he agreed.

Due to the time of day as well as being Good Friday, no initial witness interviews could be conducted before the writing of this report. VA Police Chief M. Steinmetz instructed Sergeant Wright to provide all pertinent information to VA Police Detective R. Stanbro for follow up investigation into this matter.

End of initial report.

Prepared By	Submitted Date
WRIGHT, DAVID(DAVID.WRIGHT9@VA.GOV)	03/31/2018 1358
Signature	Reviewed By/Date

Case # : 528 IR20180331-000216

DEPARTMENT OF VETERANS AFFAIRS POLICE
528 - BUFFALO VAMC
3495 BAILEY AVENUE
BUFFALO, NY, 14215

Follow Up

Reported By: **STANBRO, RACHEL**

Parent Report Information

Follow Up Report Name	Reference Number
Incident Report	**528 IR20180331-000216**
Report Recorder	**Report Disposition**
WRIGHT, DAVID	**CLOSED**
Related Number	**Tracker Number**
	334836

Follow Up Information

Narrative

Detective receives report of larceny of pharmacy controlled substances. Phone interview conducted with victim spouse to collect details of the incident. Interview request sent to OIG who declined to assist in off station interview. Case closed.

List of contacts in this report

(b) (6), (b) (7)(C) **WITNESS**

Contact # 1 (WITNESS)

Full Name

(b) (6), (b) (7)(C)

Age	Date of Birth	Gender	Race
		FEMALE	

Addresses

Street Number	Street Direction	Street Name	Street Type	Apt/Suite
(b) (6), (b) (7)(C)				

Phones :

(b) (6), (b) (7)(C)

Narrative text

On 3 April, 2018 I (Detective Rachel Stanbro) spoke with victims spouse, (b) (6), (b) (7)(C) to verify information previously collected by the initial reporting officer.
According to (b) (6), when her and her son (b)) came to the facility to pick up her husband they were that nurses aid (b) (6), would assist (b) (6), down to the pharmacy and then out to the outpatient entrance for pickup. (b) was pushed by (b) (6), via wheelchair to the outpatient pharmacy where he collected two (2) prescriptions. From there (b) (6), pushed (b) (6), to the vestibule of the outpatient entrance until pulled up in her POV. A check of the CCTV system was conducted with the following results;

Camera 9 - Outpatient Entrance (15:09:39) (b) (6), is seen pushing (b) into the outpatient vestibule. The clear plastic

Prepared By	Submitted Date
STANBRO, RACHEL(Rachel.Stanbro@va.gov)	07/01/2018 0820
Signature	**Reviewed By Date**

bag containing (b) (6), [redacted] prescriptions can be seen in [redacted] right hand as she is holding the IV pole on the wheelchair.

Camera 7 - Outpatient Vestibule (15:15:48) [redacted] is seen pulling (b) (6), [redacted] out of camera view and into the wheelchair storage area. When (b) (6), [redacted] and (b) [redacted] reenter camera view the prescription bag appears changed and is no longer held in the same manner. (b) (6), [redacted] can be seen pushing (b) (6), [redacted] up to a parked vehicle where she "tosses" the prescription bag in to the passenger front seat. She then begins to assist (b) (6), [redacted] into the seat and places something on his lap prior to closing the vehicle door.

Contact was made with nurse manager, William Walkden on 8D to verify the identity of the (b) (6), [redacted] Walkden verified that (b) (6), [redacted] was on duty the day of the incident and stated that she would be back to work on 7 April for her shift.

Contact was made with the outpatient pharmacy to verify the contents of the prescription picked up by [redacted]. Lisa verified that (b) [redacted] received his prescription of Aspirin and Oxycodone. Lisa also confirmed that a third (3) medication, previously asked about by (b) (6), [redacted] was returned to pharmacy inventory at 1420hrs on 4 April. Lisa advised (b) (6), [redacted] declined the medication (Ducosate) to the discharge pharmacist.

A follow up call was made to (b) (6), (b) [redacted] advise of the status of the investigation as well as the location of the third (3) prescription. During the conversation I received her sons (b) [redacted] information and conducted a search in NYS eJustice with no information returned. (b) (6), [redacted] advised that (b) [redacted] is currently living in her residence, temporarily.

An interview request was made to VA OIG SAC Jeff Stachowiack requesting the assistance of an agent to conduct a field interview of (b) [redacted] A second request was sent on 3 June 2018 to OIG requesting assistance which was declined by SA Jeff Stachowiak.

Due to lack of investigative leads, this report is closed within the files of this office pending receipt of further information.

Prepared By	Submitted Date
STANBRO, RACHEL(Rachel.Stanbro@va.gov)	07/01/2018 0820
Signature	Reviewed By Date

Case Number [redacted]

DEPARTMENT OF VETERANS AFFAIRS POLICE
528 - BUFFALO VAMC
3495 BAILEY AVENUE
BUFFALO, NY, 14215

Incident Report

Reported by: **KOZAKIEWICZ, PATRICIA**

Incident Type(s) Label	Offender	Incident Disposition
INCIDENTS : 90Z - OTHER OFFENSES : PHARMACY / MEDICATIONS (NON-CRIMINAL)	**, (UNKNOWN)**	**CLOSED**

Report Disposition	Method of Reporting
CLOSED	**PHONE**

Report Recorder	Manager/Supervisor On Duty	Manager/Supervisor Notified
KOZAKIEWICZ, PATRICIA		

Incident Occurred Date	Incident Occurred End Date	Incident Discovered / Called In
08/13/2018 at 1730	**08/13/2018 at 1750**	**08/13/2018 at 1900**

Location	Specific Location
WESTERN NEW YORK HCS : BUFFALO VA MEDICAL CENTER	**ADMISSIONS OUT-PATIENT WAITING AREA.**

Report Synopsis/Overview

Veteran patient reported missing four medications contained in a green bag today at 1730 in the out-patient waiting area. The medications had been filled at this facility approximately one week ago. The patient had come to the pharmacy to ask about getting a new Medicare card that he lost. The pharmacy directed the patient to the Admissions desk and asked Wess Spencer how to get in contact with Medicare. Wess gave the phone number to same and the patient put down his bag of medications and called Medicare. Veteran stated that someone took the bag of medications that were left unattended as he was on the phone or had departed the property. A search of the area by EMS, MAS, and Police met with negative results.

Contact # 1 (PATIENT)

Full Name

(b) (6), (b) (7)(C)

Addresses

Street Number	Street Direction	Street Name	Street Type	Apt/Suite
(b) (6), (b) (7)(C)				

Phones :

(b) (6), (b) (7)(C)

Contact # 2 (UNKNOWN)

Prepared By	Submitted Date
KOZAKIEWICZ, PATRICIA(PATRICIA.KOZAKIEWICZ@VA.GOV)	8-13-18
Signature	Reviewed By/Date

Case Number [redacted]

Property #1 (LOST)		
Property Reference #	Property Type	Property Category
	NARCOTICS	LOST
Property Disposition	Barcode Number	
LOST	100000024250	
Property Description	Property Location	
ORLISTAT 60MG		
Brand	Model	Serial Number
		14422522

Property #2 (LOST)		
Property Reference #	Property Type	Property Category
	10 DRUGS/NARCOTICS	LOST
Property Disposition	Barcode Number	
LOST	100000024251	
Property Description	Property Location	
MELOXICAM 15 MG		
Brand	Model	Serial Number
		14316657

Property #3 (LOST)		
Property Reference #	Property Type	Property Category
	10 DRUGS/NARCOTICS	LOST
Property Disposition	Barcode Number	
LOST	100000024252	
Property Description	Property Location	
HYDROCODONE 7.5 MG		
Brand	Model	Serial Number
		19323277

Property #4 (LOST)		
Property Reference #	Property Type	Property Category
	10 DRUGS/NARCOTICS	LOST
Property Disposition	Barcode Number	
LOST	100000024253	
Property Description	Property Location	
LORAZEPAM 2MG		
Brand	Model	Serial Number
		14373160

Narrative text

Veteran patient (b) (6), reported missing four medications contained in a green bag today at 1730 in the out-patient waiting area. The medications had been filled at this facility approximately one week ago. The patient had come to the pharmacy to ask about getting a new Medicare card that he lost. The pharmacy directed the patient to the Admissions desk and asked Wess Spencer how to get in contact with Medicare. Wess gave the phone number to (b) (6), (b) (6) and he set the bag

Prepared By	Submitted Date
KOZAKIEWICZ, PATRICIA(PATRICIA.KOZAKIEWICZ@VA.GOV)	8-13-18
Signature	Reviewed By Date

down and called Medicare.

(b) (6), called the VA Police at 1900 on 08-13-18 and reported the medication and bag missing. came to the Police sub-station to give the Police a statement this evening with a list of medications that he had in his bag.

Wess Spencer, EMS, Pharmacy, and the Police searched the area which met with negative results.

(b) stated that someone took the bag of medications that were left unattended as he was on the phone or had departed the property without them.

The following list of medications were contained in (b) (6), bag:

1. Orlistat
2. Meloxicam
3. Hydrocodone
4. Lorazepam

Prepared By: KOZAKIEWICZ, PATRICIA(PATRICIA.KOZAKIEWICZ@VA.GOV)

Submitted Date: 8-13-18

Signature:

Reviewed By/Date:

Department of Veterans Affairs

VOLUNTARY WITNESS STATEMENT

Location: VAMC

Date: 8 13 2018

I, (b) (6), (b) (7)(C) residing at or employed at Police Station

make the following statement freely and voluntarily:

I came into the VA on Bailey Ave - Buff. NY at about 5:30 PM Buff. NY

I went to the Pharmacy to see if they had my medicine Carpal which I took last they did not

They sent me to VET service they looked up the meds for Medicare

I sat 20' away and called Medicare.

I had brought my medicines with me in a green bag.

As I talked on the phone someone either took the bag with all my medicines or I forgot it. I left and returned about 7pm the people in yesterday Veterans Services and the Police all tried but couldn't find the bag

(Declarant Initials)

VA FORM JAN 1993 (R) 0024

Adobe Forms Designer 6.0

Department of Veterans Affairs

VOLUNTARY WITNESS STATEMENT *(Continuation Sheet)*

Statement of DR. M. CARRELL

1. ORLISTAT 7-1-18
2. MELOXICAM. ~~7-16-18~~
3. HYDROCODONE 8-7-18
4. LORAZEPAM. 8-7-18
5.

DR. DARWISH

2.- PROSTATE MEDICINES

TAMSULOSIN

FINASTRIDE

I have read/have had read to me the above statement consisting of _____ page(s), and certify that it is true and correct to the best of my knowledge.

No threats or promises have been made to me and no pressure or coercion of any kind has been used against me.

(b) (6), (b) (7)(C)

(Declarant) Signature

8/13/2018
(Date)

(Witness) Signature

8-13-2018
(Date)

VA FORM JAN 1993 (R) 0024

Adobe Forms Designer 6.0

Case Number [redacted]

DEPARTMENT OF VETERANS AFFAIRS POLICE
528 - BUFFALO VAMC
3495 BAILEY AVENUE
BUFFALO, NY, 14215

Incident Report

Reported by: **STANBRO, RACHEL**

Incident Type(s) (Local)	Offense	Incident Disposition
INCIDENTS : 23A-23H LARCENY/THEFT OFFENSES : 23H ALL OTHER LARCENY/THEFT : PHARMACY CONTROLLED SUBSTANCE - THEFT (FELONY)		UNFOUNDED
INCIDENTS : 23A-23H LARCENY/THEFT OFFENSES : 23F THEFT FROM MOTOR VEHICLE (EXCEPT MOTOR VEHICLE PARTS OR ACCESSORIES) : LESS THAN $1000.00 (FELONY)		UNFOUNDED

Report Disposition	Method of Report Routing	
CLOSED	POLICE SERVICE: WALK-IN	
Report Recorded	**Manager/Supervisor on Duty**	**Manager/Supervisor Notified**
STANBRO, RACHEL	RENNE, KENNETH	NO
Incident Occurred Date	**Incident Occurred End Date**	**Incident Discovered/Called In**
02/27/2018 at 0900	03/19/2018 at 1300	03/21/2018 at 1200
Location	**Specific Location**	
WESTERN NEW YORK HCS : BUFFALO VA MEDICAL CENTER : OFFSITE	STAFFORD, NY	

Report Synopsis/Overview

Detective took a report of theft of controlled substances from a motor vehicle. Veteran was in-patient at Buffalo VAMC and released his personal vehicle to his NOK. Upon discharge veteran discovered half of prescription missing. Due to the removal of the vehicle from property and failed CCTV system, investigation is closed.

Contact # 1 (NONE)

Full Name

(b) (6), (b) (7)(C)

[redacted]

Phones :

(b) (6), (b) (7)(C)

Contact # 2 (REPORTING PERSON)

Prepared By	Submitted Date
STANBRO, RACHEL(Rachel.Stanbro@va.gov)	
Signature	**Reviewed By/Date**

Case Number [redacted]

Addl Name [redacted]

(b) (6), (b) (7)(C)

Aliases [redacted]

(b) (6), (b) (7)(C)

Addresses

Street Number	Street Direction	Street Name	Street Type	Apt/Suite

(b) (6), (b) (7)(C)

Phones :

(b) (6), (b) (7)

Vehicle #1 (UNKNOWN)

Plate Type	Plate Number	Vehicle Make	Vehicle Style
TRUCK	UNKNOWN	(b) (6), (b)	4 DOOR VEHICLE
Vehicle Model	Expiration	VIN	Plate State
(b) (6), (b)			
Year	Vehicle Color	Owner	
		(b) (6), (b) (7)	

Property #1 (STOLEN)

Property Reference #	Property Type	Property Category
	10 DRUGS/NARCOTICS	STOLEN
Property Disposition	**Barcode Number**	
STOLEN	100000024171	
Property Description	**Property Location**	
HYDROCODONE 7.5/ ACETAMINOPHEN 325		
Approximate Size	**Property Color**	**Owner**
TABLET	WHITE	(b) (6), (b) (7)(C)
Approximate Value	**Quantity**	**Total**
$5.00	34	$170.00

Prepared By: STANBRO, RACHEL(Rachel.Stanbro@va.gov)

Submitted Date

Signature

Reviewed By/Date

Case Number [redacted]

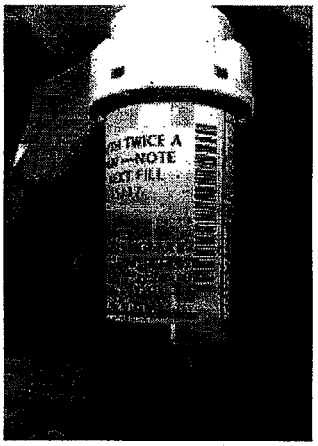
Digital Media List

Digital Media # 1

Title
PRESCRIPTION BOTTLE

Description
Center Label

Digital Media # 2



Title
PRESCRIPTION BOTTLE

Description
Right Label

Prepared By
STANBRO, RACHEL(Rachel.Stanbro@va.gov)

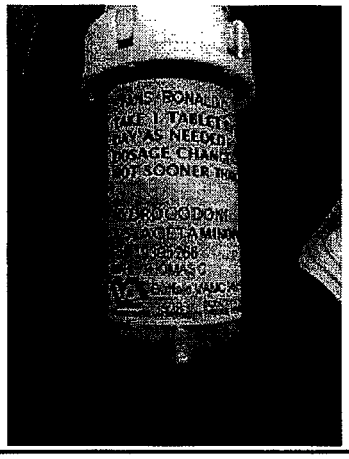
Submitted Date

Signature

Reviewed By Date

Case Number [redacted]

Digital Media # 3



Title

PRESCRIPTION BOTTLE

Description

Left Label

Narrative text

On March 21, 2018 at approximately 1200hrs, SGT Borkowski requested that I (Detective Rachel Stanbro) come to the police substation to meet with a veteran that needed to file a report as he was unable to assist him while he was conducting timekeeping.

Upon arrival to the substation I met with (b) (6), (b) who had been recently discharged from the facility on 19 March. (b) explained that on 27 February he came to the Buffalo VAMC for a Dental appointment and experienced a stroke. At that time he was admitted for treatment and his personal vehicle, (b) (6), (b) (7) , was left legally parked and locked in the parking garage, first level. During his treatment, (stated that his sister, (b) (6), (b) was given the keys to his truck and she left property with it for an undisclosed amount of days and returned to her home in Stafford, New York. (b) stated that inside his truck he had a prescription bottle of Hydrocodone 7.5/Acetaminophen 325 (prescription full would be 60) and an undisclosed amount of cash in his center counsel. (b) stated that when he opened his prescription bottle he discovered it was missing pills recalling that it was "full to the top of the bottle" when he came to the facility. After inspecting the bottle I counted that there were 26 tablets remaining in the container. A check was conducted with Pharmacy Manager Nancy Fucile at the Buffalo VAMC in-patient pharmacy to identify the last date a refill was made on (b) prescription. Records indicated that the refill was done on 16 October 2017 for a 60 day supply.

(b) stated several times during his interview that he did not take the medication on a regular basis and did not feel it was necessary for him to see his primary care physician for a partial refill, he only wanted to report the medication missing incase someone overdosed from it.

This report is closed as unfounded as the vehicle was removed from VAMC property, no forced entry was used to access the vehicle and the medication was still present in the vehicle. An attempt to conduct a review of CCTV was not possible due to the camera systems being inoperable in the parking garage.

Prepared By

STANBRO, RACHEL(Rachel.Stanbro@va.gov)

Submitted Date

Signature

Reviewed By/Date

Case Number **528A8 IR20180412-000152**

DEPARTMENT OF VETERANS AFFAIRS POLICE
528A8 - SAMUEL S. STRATTON VAMC-ALBANY
113 HOLLAND AVENUE
ALBANY, NY, 12208

Incident Report

Reported by: **RUSSELL, GERALD E III**

Incident Types Label	Offender	Incident Disposition
INCIDENTS : 23A-23H LARCENY/THEFT OFFENSES : 23H ALL OTHER LARCENY/THEFT : PHARMACY CONTROLLED SUBSTANCE - THEFT (FELONY)	**, (SUSPECT)**	**RELEASED TO OUTSIDE LE AGENCY**

Report Disposition	Method of Reporting
CLOSED	**PHONE**

Report Recorder	Manager/Supervisor On Duty	Manager/Supervisor Notified
RUSSELL, GERALD E III	**OTIS, LEILA A**	**NO**

Incident Occurred Date	Incident Occurred End Date	Incident Discovered / Called In
04/07/2018 at 1600	**04/07/2018 at 1610**	**04/11/2018 at 1049**

Location	Specific Location
SAMUEL S. STRATTON VA MEDICAL CENTER-ALBANY	**OFF PROPERTY**

Report Synopsis/Overview

Veteran called the medical center to report that his medication was not received and suspected it had been stolen by someone in the United States Post Office. Initial investigation completed and case referred to United States Postal Service Office of Inspector General.

[redacted] Contact # 1 (SERVICE CHIEF)

Full Name

TERRI WANK

Drivers License	Drivers LicenseState	Email Address
(b) (6), (b) (7)(C) [redacted]		

Department	Title
OTHER	**CHIEF OF PHARMACY**

[redacted] Addresses

Street Number	Street Direction	Street Name	Street Type	Apt./Suite
113		**HOLLAND**	**AVENUE**	

City	State	Zip	Country	Address Type
ALBANY	**NY**	**12208**	**USA**	**WORK**

Street Number	Street Direction	Street Name	Street Type	Apt./Suite
(b) (6), (b) (7)(C) [redacted]				

City	State	Zip	Country	Address Type

Prepared By:	Submitted Date
RUSSELL, GERALD E III(GERALD.RUSSELL@VA.GOV)	04/16/2018 0951

Signature	Reviewed By/Date
	OTIS, LEILA A 04/23/2018 0755

Case Number 528A8 IR20180412-000152

(b) (6), (b) (7)(C)

Contact # 2 (OUTSIDE LAW ENFORCEMENT)

Full Name			
DIANA FEESER			
Drivers License		Drivers LicenseState	Email Address
			DFEESER@USPSOIG.GOV
Age	Date of Birth	Gender	Race
		FEMALE	WHITE
Department			Title
			SPECIAL AGENT

Notes

UNITED STATES POSTAL SERVICE OFFICE OF THE INSPECTOR GENERAL

Addresses

Street Number	Street Direction	Street Name	Street Type	Apt./Suite
PO BOX 1350				

City	State	Zip	Country	Address Type
TROY	NY	12181	USA	WORK

Phones :

(WORK) 5182682103

Contact # 3 (REPORTING PERSON)

Full Name

(b) (6), (b) (7)(C)

Notes

VETERAN - (b)

Addresses

Street Number	Street Direction	Street Name	Street Type	Apt./Suite
(b) (6), (b) (7)(C)				

ype

Phones :

(b) (6), (b) (7)(C)

Contact # 4 (SUSPECT)

Narrative text

On April 11, 2018 at about 8:49AM Veteran (b) (6), (b) called the medical center to report that his medication was not received through the mail. (b) (6), was inadvertently transferred to the VA Police by the Operator and this is the origin of how the complaint was received. I took the telephone call and gathered the details of (b) (6), complaint. (b) (6), told me that he was supposed to receive

Prepared By:	Submitted Date
RUSSELL, GERALD E III(GERALD.RUSSELL@VA.GOV)	04/16/2018 0951
Signature	**Reviewed By/Date**
	OTIS, LEILA A 04/23/2018 0755

Tramadol 50mg through the mail re-order program with the Veterans Affairs (VA), but he never did. (b) (6), explained that when he called the post office they said he had received the medication. (b) (6), further explained that this is why he suspected the Tramadol had been stolen by someone in the United States Postal Service. (b) (6), related to me that he had video surveillance of his mailbox area and he could see that only the postman had been there and no once else. (b) (6), offered the video surveillance as proof. After gathering the initial information I told (b) (6), that I would contact the Postal Service Inspector General about the incident and requested he not contact anyone in the local post office until after the Postal Inspector General contacted him. I also advised (b) (6), that I would notify our Pharmacy Chief of his complaint and then transferred his call to the VA Pharmacy.

A few minutes after our initial conversation (b) (6), (b) (7)(C) called me back and reported that his sister had contacted the local post office and she was informed that someone had signed for the medication. (b) (6), told me he looked at the signature and it was not his signature. (b) (6), related that he appreciated everything I was doing and told me he wanted me to know that he would press charges against whoever signed his name and stole his medication.

At about 9:20AM I notified Terry Wank, VA Chief of Pharmacy, regarding this incident reported from (b) (6),. I advised Wank that I referred (b) (6), to the outpatient pharmacy to report his missing medications so he could obtain a refill. I asked Wank if she could find a tracking number for the medication and she agreed to do so.

At about 2:40PM Wank provided me with the tracking information for the Tramadol sent to (b) (6),. Wank told me that there was a signature associated with the delivery and that the medication originated from the South Carolina Veterans Affairs warehouse. I subsequently reviewed the tracking information and confirmed the medication was mailed from South Carolina on April 04, 2018 at 6:00PM and showed delivery, with signature confirmation, to (b) (6), address in Johnsonville, NY on April 07, 2018 at 4:00PM. The signature was also included in the tracking information provided by Wank.

At about 2:50PM I contacted the United States Postal Service Inspector General, Special Agent Diana Feeser, to report this incident and request referral to her agency.

On April 12, 2018 at about 11:50AM Special Agent Feeser returned my call and I provided her with a briefing of this incident, to which she subsequently accepted the referral. Special Agent Feeser requested that I try to obtain a signature for (b) (6), that the VA may have on file and I agreed.

The initial investigation has been completed and this case was referred to United States Postal Service, Office of Inspector General. Referral was accepted and the Postal Service shall be the lead investigating agency from this point forward, with assistance from VA Police, as requested.

Prepared By:	Submitted Date
RUSSELL, GERALD E III(GERALD.RUSSELL@VA.GOV)	04/16/2018 0951
Signature	**Reviewed By/Date**
	OTIS, LEILA A 04/23/2018 0755

Case Number **528A8 IR20180131-000040**

DEPARTMENT OF VETERANS AFFAIRS POLICE
528A8 - SAMUEL S. STRATTON VAMC-ALBANY
113 HOLLAND AVENUE
ALBANY, NY, 12208

Incident Report

Reported by: **RUSSELL, GERALD E III**

Incident Types Label	Offender	Incident Disposition
INCIDENTS : 23A-23H LARCENY/THEFT OFFENSES : 23H ALL OTHER LARCENY/THEFT : PHARMACY CONTROLLED SUBSTANCE - THEFT (MISDEMEANOR)	**(b) (6), (b) (7)(C) (SUSPECT)**	**CLOSED**

Report Disposition	Method of Reporting
PENDING INVESTIGATION	**VA EMPLOYEE**

Report Recorder	Manager/Supervisor On Duty	Manager/Supervisor Notified
RUSSELL, GERALD E III	**OTIS, LEILA A**	**YES**

Incident Occurred Date	Incident Occurred End Date	Incident Discovered / Called In
01/02/2018 at 0550	**01/02/2018 at 0553**	**01/02/2018 at 0659**

Location	Specific Location
SAMUEL S. STRATTON VA MEDICAL CENTER-ALBANY : NURSES STATION	**WARD 8B MEDICATION ROOM (PYXIS)**

Report Synopsis/Overview

VA Police received report of possible drug diversion, on Ward 8B, from the Facility Controlled Substance Coordinator. VA OIG notified and deferred to VA Police for further investigation. A criminal investigation was initiated by VA Police.

Contact # 1 (REPORTING PERSON)

Full Name

AIDEN SCHWEITZER

Drivers License	Drivers LicenseState	Email Address
(b) (6), (b) (7)(C)		

Department	Title
DIRECTOR'S SUITE	**CONTROLLED SUBSTANCES COORDINATOR**

Addresses

Street Number	Street Direction	Street Name	Street Type	Apt./Suite	Address Type
(b) (6), (b) (7)(C)					

Street Number	Street Direction	Street Name	Street Type	Apt./Suite
113		**HOLLAND**	**AVENUE**	

Prepared By:	Submitted Date
RUSSELL, GERALD E III(GERALD.RUSSELL@VA.GOV)	01/31/2018 0857

Signature	Reviewed By/Date
	OTIS, LEILA A 02/18/2018 1239

Case Number 528A8 IR20180131-000040

City	State	Zip	Country	Address Type
ALBANY	NY	12208		WORK

Phones :

(N/A) 518-626-6734

Contact # 2 (VICTIM)

Full Name

U.S. GOVERNMENT

Addresses

Street Number	Street Direction	Street Name	Street Type	Apt./Suite
113		HOLLAND	AVENUE	

Street Number	Street Direction	Street Name	Street Type	Apt./Suite
113		HOLLAND	AVENUE	

City	State	Zip	Country	Address Type
ALBANY	NY	12208	USA	OTHER

Contact # 3 (SUSPECT)

Full Name

(b) (6), (b) (7)(C)

Gender Race

Addresses

Street Number	Street Direction	Street Name	Street Type	Apt./Suite

(b) (6), (b) (7)(C)

Phones :

(b) (6), (b) (7)(C)

Contact # 4 (WITNESS)

Full Name

SHELBY PAINTON

(b) (6), (b) (7)(C)

Department

NURSING SERVICE

Title

REGISTERED NURSE

Addresses

Street Number	Street Direction	Street Name	Street Type	Apt./Suite

(b) (6), (b) (7)(C)

Prepared By:	Submitted Date
RUSSELL, GERALD E III(GERALD.RUSSELL@VA.GOV)	01/31/2018 0857

Signature	Reviewed By/Date
	OTIS, LEILA A 02/18/2018 1239

Case Number **528A8 IR20180131-000040**

City	State	Zip	Country	Address Type
(b) (6), (b) (7)(C)				

Street Number	Street Direction	Street Name	Street Type	Apt./Suite
113		**HOLLAND**	**AVENUE**	**WARD 8B**

City	State	Zip	Country	Address Type
ALBANY	**NY**	**12208**	**USA**	**WORK**

Narrative text

On January 02, 2018 at about 2:00PM VA Police received a report of possible drug diversion, on Ward 8B, from Aiden Schweitzer (Albany VAMC Controlled Substance Coordinator). On January 02, 2018 at about 2:30PM SA Walenta, of the VA OIG-CID, was notified and deferred investigation to VA Police. A criminal investigation was initiated.

Prepared By:	Submitted Date
RUSSELL, GERALD E III(GERALD.RUSSELL@VA.GOV)	01/31/2018 0857
Signature	**Reviewed By/Date**
	OTIS, LEILA A 02/18/2018 1239

Case # : 528A8 IR20190429-000240

DEPARTMENT OF VETERANS AFFAIRS POLICE
528A8 - SAMUEL S. STRATTON VAMC-ALBANY
113 HOLLAND AVENUE
ALBANY, NY, 12208

Incident Report

Reported By: **RUSSELL, GERALD E III**

Incident Types Label	Offender	Incident Disposition
INCIDENTS : 23A-23H LARCENY/THEFT OFFENSES : 23H ALL OTHER LARCENY/THEFT : PHARMACY CONTROLLED SUBSTANCE - THEFT (FELONY)	**(b) (6), (b) (7) (b) (6), (b) (SUSPECT)**	

Report Disposition	Method of Reporting
PENDING INVESTIGATION	**VA EMPLOYEE**

Incident Occurred Date	Incident Occurred End Date	Incident Discovered / Called In
04/29/2019 at 0545	**04/29/2019 at 0600**	**04/29/2019 at 0540**

Location	Specific Location
SAMUEL S. STRATTON VA MEDICAL CENTER-ALBANY : PATIENT CARE	**ICU**

Manager/Supervisor On Duty	Manager/Supervisor Notified
RUSSELL, GERALD E III	**YES**

Report Synopsis/Overview

On 4/29/19 at 0545 the ICU notified VA Police of a discrepancy during a controlled substances count. LT Russell responded and secured all remaining controlled substances from the Nursing Supervisor. Case referred to Detective and Controlled Substance Coordinator for follow-up investigation.

List of supplemental reports

Follow Up 528A8 IR20190429-000240_1
Follow Up 528A8 IR20190429-000240_2

List of contacts in this report

GREMBOCKI, RICK	**NONE**
SCHWEITZER, AIDEN	**NONE**
GOVERNMENT, U.S.	**PROPERTY OWNER**
WANK, TERRI	**PROPERTY OWNER**
KURIAN, JESSYMOL	**REPORTING PERSON**
(b) (6), (b) (7)(C)	**SUSPECT**
RIOS, JENNIFER	**WITNESS**
VILLEGAS, RENAN	**WITNESS**

Contact # 1 (PROPERTY OWNER)

Full Name

U.S. GOVERNMENT

Addresses

Street Number	Street Direction	Street Name	Street Type	Apt./Suite
113		**HOLLAND**	**AVENUE**	

City	State	Zip	Country	Address Type

Prepared By:	Submitted Date
RUSSELL, GERALD E III(GERALD.RUSSELL@VA.GOV)	04/29/2019 0741

Signature	Reviewed By/Date
	GIBBONS, THOMAS 04/30/2019 0709

Case # : 528A8 IR20190429-000240

ALBANY	NY	12208	USA	WORK

Contact # 2 (REPORTING PERSON)

Full Name

JESSYMOL KURIAN

(b) (6), (b) (7)(C)

[redacted]

Department	Title
NURSING SERVICE	RN

Addresses

Street Number	Street Direction	Street Name	Street Type	Apt./Suite
113		HOLLAND	AVENUE	ICU

City	State	Zip	Country	Address Type
ALBANY	NY	12208	USA	WORK

Contact # 3 (SUSPECT)

Full Name

(b) (6), (b) (7)(C)

[redacted]

Addresses

Street Number	Street Direction	Street Name	Street Type	Apt./Suite
113		HOLLAND	AVENUE	ICU

City	State	Zip	Country	Address Type
ALBANY	NY	12208	USA	WORK

Contact # 4 (WITNESS)

Full Name

RENAN VILLEGAS

(b) (6), (b) (7)(C)

[redacted]

Race

Department	Title
NURSING SERVICE	REGISTERED NURSE

Prepared By:	Submitted Date
RUSSELL, GERALD E III(GERALD.RUSSELL@VA.GOV)	04/29/2019 0741

Signature	Reviewed By/Date
	GIBBONS, THOMAS 04/30/2019 0709

Case # : 528A8 IR20190429-000240

Addresses

Street Number	Street Direction	Street Name	Street Type	Apt./Suite
113		HOLLAND	AVENUE	ICU

City	State	Zip	Country	Address Type
ALBANY	NY	12208	USA	WORK

Contact # 5 (WITNESS)

Full Name

JENNIFER RIOS

(b) (6), (b) (7)(C)

[redacted]

NURSING SERVICE

NURSING SUPERVISOR

Addresses

Street Number	Street Direction	Street Name	Street Type	Apt./Suite
113		HOLLAND	AVENUE	

City	State	Zip	Country	Address Type
ALBANY	NY	12208	US	WORK

Phones :

(WORK) 51862625000 EX 66620

Property #1 (EVIDENCE)

Property Reference #	Property Type	Property Category
1	10 DRUGS/NARCOTICS	EVIDENCE

Property Disposition	Barcode Number
IN CUSTODY	100000024221

Property Description	PropertyLocation
LORAZEPAM 1MG TABLETS	POLICE SERVICE PROPERTY ROOM

Approximate Size	Property Color	Owner
	WHITE	U.S. GOVERNMENT

Approximate Value	Quantity	Total
$0.00	23	

Narrative text

On April 28, 2019 from 7:00PM until April 29, 2019 at 7:00AM I, Lieutenant Gerald E. Russell III was assigned uniformed supervisory police duties at the Stratton VA Medical Center, Albany, NY 12208.

On April 29, 2019 at about 5:45AM the intensive care unit (ICU) notified VA Police Dispatch of a discrepancy during a controlled substances count. I responded to the ICU and was met by Registered Nurse Jessymol Kurian, who told me that

Prepared By: RUSSELL, GERALD E III(GERALD.RUSSELL@VA.GOV)

Submitted Date 04/29/2019 0741

Signature

Reviewed By/Date GIBBONS, THOMAS 04/30/2019 0709

while conducting a controlled substance inventory, of the ICU pyxis machine, with RN Renan Villegas, that she discovered one (1) tablet of Lorazepam 1mg was missing from the medication drawer. I requested that she notify Nursing Supervisor Jennifer Rios and have her respond to the ICU.

At about 5:52AM Rios arrived at the ICU and conducted a joint inventory with Kurian. Rios subsequently removed the remaining Lorazepam 1mg and handed them to me. There are a total of twenty-three (23) tablets contained in three (3) packages. One (1) of the packages has four (4) pockets for tablets, but contains only three (3). Rios also provided me with the controlled substance pxyis printouts which shows the discrepancy when counted by Kurian and Villegas . Additionally, a separate printout shows that the last person who accessed the Lorazepam was (b) (6), (b) (7) on April 22, 2019.

I weighed and photographed the Lorazepam 1mg tablets (11.39 grams). Photos of the tablets and pyxis printouts have been attached to this report. The Lorazepam tablets have been processed into the evidence depository.

I conducted a brief interview with Kurian, who provided a sworn written statement. I have attached this statement to the report .

I have briefed both the VA Chief of Police and the Detective of this incident . Chief Gibbons stated he would notify the VA Controlled Substance Coordinator. This case has been referred to both the VA Police Detective and VA Controlled Substance Coordinator for follow-up investigation.

Prepared By:	Submitted Date
RUSSELL, GERALD E III(GERALD.RUSSELL@VA.GOV)	04/29/2019 0741
Signature	**Reviewed By/Date**
	GIBBONS, THOMAS 04/30/2019 0709

Case # : 528A8 IR20190429-000240_1

DEPARTMENT OF VETERANS AFFAIRS POLICE
528A8 - SAMUEL S. STRATTON VAMC-ALBANY
113 HOLLAND AVENUE
ALBANY, NY, 12208

Follow Up

Reported By: **MAESTRI, CLIFF**

Parent Report Information

Follow Up Report Main	Reference Number
Incident Report	**528A8 IR20190429-000240**
Report Recorder	Report Disposition
RUSSELL, GERALD E III	**PENDING INVESTIGATION**
Related Number:	Tracking Number
	521603

Follow Up Information

Synopsis

On 04/29/2019 at approximately 0700hrs., the VAPD Detective was assigned a case for possible drug diversion/theft. A follow up was done with the Controlled Substance Coordinator. The pill was recovered.

List of contacts in this report

GREMBOCKI, RICK	**NONE**
SCHWEITZER, AIDEN	**NONE**

Contact # 1 (NONE)

Full Name

RICK GREMBOCKI

(b) (6), (b) (7)(C) [redacted]

Addresses

Street Number	Street Direction	Street Name	Street Type	Apt./Suite
113		**HOLLAND**	**AVENUE**	

City	State	Zip	Country	Address Type
ALBANY	**NY**	**12208**	**USA**	**WORK**

Contact # 2 (NONE)

Full Name

AIDEN SCHWEITZER

(b) (6), (b) (7)(C) [redacted]

Email Address

Age	Date of Birth	Gender	Race

Prepared By:
MAESTRI, CLIFF(Cliff.Maestri@va.gov)

Submitted Date
04/29/2019 1005

Signature

Reviewed By/Date
GIBBONS, THOMAS 05/01/2019 1218

Case # : 528A8 IR20190429-000240_1

(b) (6), (b) (7)(C)

Department	Title
DIRECTOR'S SUITE	CONTROLLED SUBSTANCES COORDINATOR

Addresses

Street Number	Street Direction	Street Name	Street Type	Apt./Suite

(b) (6), (b) (7)(C)

Street Number	Street Direction	Street Name	Street Type	Apt./Suite
113		HOLLAND	AVENUE	

City	State	Zip	Country	Address Type
ALBANY	NY	12208	USA	WORK

Phones :

(b) (6), (b) (7)(C)

Narrative text

On Monday April 29th, 2019 at approximately 0700hrs., while I (Detective Cliff Maestri Badge #1349) was working plain clothes police operations at the Albany New York Veterans Affairs Campus I was assigned a case of potential drug diversion /t heft from the ICU.

Lieutenant Russell came to my office and explained that around 0600hrs., he was approached by staff about a potential drug diversion case from the ICU (see associated report). He explained to me that while they were conducting an inventory they noticed that a blister pack of Lorazepam was cut open and missing one single 1mg dose.

After speaking to Russell I conducted a follow up interview with the Controlled Substance Coordinator (Later identified as Aiden Schweitzer) and explained to him what was stated in the above referenced IR.

Schweitzer stated he would contact pharmacy and have a tech meet him on the ICU floor to open the Pyxis and see if the pill fallen inside of it.

At approximately 0930hrs., Schweitzer and a pharmacy tech (later identified as Rick Grembocki) stopped by police services and stated that they had conducted a search on the inside of the Pyxis and recovered the single dose 1mg Lorazepam tablet which was confirmed by the Pyxis system and both Schweitzer and Grembocki.

Due to this change of events and recovery of the narcotic, the evidence will be released back at a later date.

I returned back to patrol at approximately 1000hrs.

I recommend this case be closed.

Prepared By:	Submitted Date
MAESTRI, CLIFF(Cliff.Maestri@va.gov)	04/29/2019 1005
Signature	**Reviewed By/Date**
	GIBBONS, THOMAS 05/01/2019 1218

Case # : **528A8 IR20190429-000240_2**

DEPARTMENT OF VETERANS AFFAIRS POLICE
528A8 - SAMUEL S. STRATTON VAMC-ALBANY
113 HOLLAND AVENUE
ALBANY, NY, 12208

Follow Up

Reported By: **BURNS, THOMAS**

Parent Report Information

Follow Up Report Main	Reference Number
Incident Report	**528A8 IR20190429-000240**
Report Recorder	Report Disposition
RUSSELL, GERALD E III	**PENDING INVESTIGATION**
Related Number:	Tracking Number
	521603

Follow Up Information

Synopsis

On April 29, 2019 at approximately 15:15 the evidence that was obtained by VA Police was returned to the pharmacy. The evidence was obtained due to the possibility of drug diversion due to a missing tablet. The missing tablet was located, and it was deemed that there was no longer a need for police involvement.

List of contacts in this report

WANK, TERRI **PROPERTY OWNER**

Contact # 1 (PROPERTY OWNER)

Full Name

TERRI WANK

Addresses

Street Number	Street Direction	Street Name	Street Type	Apt./Suite
113		**HOLLAND**	**AVENUE**	

City	State	Zip	Country	Address Type
ALBANY	**NY**	**12208**		

Narrative text

On April 29, 2019 at approximately 15:15HRS I, Officer T. Burns, was assigned uniformed police patrol at the Stratton VA Medical Center, located at 113 Holland Ave, Albany, NY 12208.
On April 29, 2019 at approximately 15:15 the evidence that was obtained by VA Police was returned to the Chief of Pharmacy Terri Wank. The evidence was obtained due to the possibility of drug diversion due to a missing tablet. The missing tablet was located, and it was deemed that there was no longer a need for police involvement.
Terri Wank signed 3524 and evidence was released.

Prepared By:	**Submitted Date**
BURNS, THOMAS(Thomas.Burns@va.gov)	04/29/2019 1542
Signature	**Reviewed By/Date**
	GIBBONS, THOMAS 05/01/2019 1216

Department of Veterans Affairs
VA Police
Northport
Investigative Report
Investigative Report#: 2018-06-19-1400-9978

VA Facility: Northport **Date/Time Printed** 6/29/2018 14:43

This Document is to be handled in accordance with the Privacy Act

Contents shall not be disclosed, discussed, or shared with individuals unless they have a direct need-to-know in the performance of their official duties. The document(s) are to be handled in accordance with For Official Use Only procedures.

Date/Time Received	6/19/18 14:00 PM
Date/Time of Offense:	6/4/18 09:27 AM
Location:	Off Station/UPS Delivery
Investigating Officer	DAVID XAVIER
Incident Synopsis:	Report of a tampered/damaged narcotics package that was delivered to a veteran via UPS.
Classification Code:	Non-Criminal Information(F)
Final Disposition:	**Case Closed**
Initial Disposition:	Case Referred to VA OIG
Case Status:	CLOSED

Use of Force

OC Weapon used:	No
Baton Used:	No
Firearm Drawn:	No
Firearm Used:	No

Complainant

Name:	Christine Palathinkal
Status:	Employee - Clinical
Work Address	79 Middleville Road Northport, NY 11768
Work Phone	6312614400
Statement	

Victim

Name:	(b) (6), (b)		
Gender:		**Ethnicity:**	
Status:	Patient		
Driver's License:		**State:**	GENERAL
Work Address:			
Work Phone:			
Treatment:	No		

Suspect

Name:	SUSPECT UNKNOWN				
SSN:	U	**DOB:**		**Age:**	
Gender:		**Ethnicity:**		**Height:**	' "
Weight:		**Hair Color:**		**Eye Color:**	
Skin Tone:		**Mark:**			
Status:					

Facility: Northport IR#: 2018-06-19-1400-9978

Driver's License Number: **License State:**

Home Address:

Home Phone:

Work Address:

Work Phone:

Offense(s): Non-Criminal: Information(F)

Violation(s):

Narrative

Origin	Walk in to Police Administration.
Initial Observation	See investigation.
Investigation	At the above time and place, the complainant states that the daughter of a veteran, (b) (6), (b) (7) , contacted her father's primary care physician, Dr. Honkanen, to report missing 5mg Oxycodone pills from her father's prescription that was delivered via UPS. On 5/31/18 NPVAMC Outpatient Pharmacy dispensed 90 tablets of 5mg Oxycodone and that prescription was shipped via UPS to the veteran, (b) (6), (b) (7)(C) (tracking #1A5190XA268120248) and was delivered to the veteran's house and the package was signed for by the veteran's daughter, (b) (6), (b) (7) . The veteran's daughter states that only 51 of 90 pills were in the package, and the packaging were damaged. A claim was made to UPS (claim#61585437). UPS security, David McGinnis was contacted (631-756-3853). UPS states that an empty package was found and the items were discarded. He will conduct an internal investigation. Case referred to Chris Wagner of the VAOIG.

Investigating Officer: DAVID XAVIER **Signature:**

Badge: 4529-ON **Date:** 6/29/18

Printed by: DAVID XAVIER

< < < End of Report > > >

Follow Up

Investigator: DAVID XAVIER **Date/Time:** 6/29/2018 2:41:44PM

On 6/29/18 the complainant reported that the veteran was present on 6/28/18 with Dr. Honkanen with his son (b) (6), He reported that he was shorted 19 oxycodone pills from a prescription of 39 pills that were a replacement of the above incident.

The delivery was shipped via UPS on 6/18/18 from the Outpatient Pharmacy and signed for on 6/20/18. The veteran and his son reported the shortage during the visit, not upon delivery.

UPS Tracking #1ZA5190XA268240538.

Dr. Honkanen reported that the veteran would prefer to come off the prescription entirely.

Case Number 632 IR20190520-000032

DEPARTMENT OF VETERANS AFFAIRS POLICE
632 - NORTHPORT VAMC
79 MIDDLEVILLE ROAD
NORTH PORT, NY, 11768

DET.

Incident Report

Reported by: WILD, LISA M

Incident Types Label	Offender	Incident Disposition
INCIDENTS : NON UCR INCIDENT : LOST/MISSING PROPERTY-OTHER THAN KEYS-PIV-ID-ACCESS CARD		CLOSED

Report Disposition	Method of Reporting	
CLOSED		
Report Recorder	**Manager/Supervisor On Duty**	**Manager/Supervisor Notified**
WILD, LISA M		
Incident Occurred Date	**Incident Occurred End Date**	**Incident Discovered / Called In**
05/14/2019 at 1300	05/14/2019 at 1315	05/20/2019 at 1100

Location	Specific Location
NORTHPORT VA MEDICAL CENTER	OPERATING ROOM

Report Synopsis/Overview

During a controlled substance inspection performed by employee Vanessa Reed in the OR, a discrepancy was discovered of missing Fentanyl (200mcg).

Contact # 1 (REPORTING PERSON)

Full Name

VANESSA REED

Addresses

Street Number	Street Direction	Street Name	Street Type	Apt./Suite
79		MIDDLEVILLE	ROAD	

City	State	Zip	Country	Address Type
NORTHPORT	NY	11768	USA	WORK

Phones :

(WORK) 631 261-4400 EX 5671

Contact # 2 (VICTIM)

Full Name

(b) (6), (b) (7)(C)

Department	Title
	PATIENT

Addresses

Street Number	Street Direction	Street Name	Street Type	Apt./Suite
79		MIDDLEVILLE	ROAD	

City	State	Zip	Country	Address Type
NORTHPORT	NY	11768	USA	OTHER

Prepared By: **Submitted Date**

WILD, LISA M(LISA.WILD2@VA.GOV)

Signature **Reviewed By/Date**

Case Number 632 IR20190520-000032

Contact # 3 (SUSPECT)

Full Name

(b) (6), (b) (7)(C) [redacted]

Addresses

Street Number	Street Direction	Street Name			Street Type	Apt./Suite
79		MIDDLEVILLE			ROAD	
City		State	Zip	Country		Address Type
NORTHPORT		NY	11768	USA		WORK

Phones

(WORK) 631 261-4400 EX 7484

Narrative text

On 5/20/18 at approx. 11:10, I responded to Pulmonary section to speak with caller Vanessa Reed in reference to a drug discrepancy . During the interview, Vanessa Reed (employee)stated that medication Fentanyl (200mcg) was signed out of from pharmacy by (b) [redacted] is missing. This medication chart indicates that the medication was never given to the patient (b) (6), (b) (7) and was never returned to the pharmacy. I contacted [redacted] (b) [redacted] who stated that the medication is indicated in the system but is unable to retrieve that info due to the timeframe and that Dr. Barcelon is the only one that has access to that. Dr. Barcelona is currently out on leave. I requested that (b) (6), follow up with Dr. Barcelon when he returns and provide the Police with the information needed. No further Police action at this time.

Prepared By: WILD, LISA M(LISA.WILD2@VA.GOV)

Submitted Date

Signature

Reviewed By/Date

Department of Veterans Affairs
VA Police
Hudson Valley HCS
Investigative Report
Investigative Report#: 2018-11-05-1155-4139

VA Facility: Hudson Valley HCS **Date/Time Printed** 6/6/2019 12:14

Date/Time Received	11/5/18 11:55 AM
Date/Time of Offense:	10/12/18 14:55 PM
Location:	Building 6, Ward 6CD Medicine Room
Investigating Officer	DAVID WARNER
Incident Synopsis:	The Ward 6CD Nurse Manager reports discovery of a pattern of a ward LPN possibly diverting and then falsifying the wasting of residual 2.5 mg half Oxycodone IR narcotic pills. Initial interview of Nurse Manager completed.
Classification Code:	Non-Criminal Information(F)
Final Disposition:	**Case Closed**
Initial Disposition:	Initial Investigation Completed
Case Status:	CLOSED

Use of Force

OC Weapon used:	No
Baton Used:	No
Firearm Drawn:	No
Firearm Used:	No

Complainant

Name:	(b) (6), (b) (7)(C)
Status:	Employee - Clinical
Work Address	VA Hudson Valley health Care System 2094 Albany Post Rd. Montrose, NY 10548

Work Phone 9147374400

Statement

"On 10/12/18 at approximately 11 AM I was informed that a piece of tablet was found in the pill cutter in the medication cart on the C Side of the unit. I took the pill and put it in the waste bin in the medication room. On 10/20/18 a piece of orange pill was found in the pill cutter in the Medication cart on the C Side by the Medication nurse Da-Eu Euam . She gave the medication to the charge nurse Helen Ogaree. On 10/21/18 a piece of orange pill was found in the pill cutter in the Medication Cart on the C Side by Helen Ogaree RN and Cheryl White LPN. The pills were left for me in my office. I received them on 10/22/18 at 7:30 AM. These pills were found at the end of 12 midnight shift to 8AM Shift. (b) [redacted] is the nurse that worked all three shifts where the pills were found. On 10/26/18 at 8AM I met with (b) [redacted]. I explained to her that I found control substance in the medication cart at the end of her shift. I requested a report of Contact from her. (b) responded, "don't ask me for any report of contact until you show me evidence." This meeting was with (b) (b) (6), and Kim Freeman from the union. I followed up with an email to (b) (b) (6), requesting the report of Contact in writing.

I also requested a report of contact (b) (6), (b) (7) , the RN that witness the waste. I was told that, "I am not writing any report of contact, I did not witness any wast. This information was escalated to my supervisor Sherlon Pressley. (b) [redacted] has been placed on administrative duties until (6), further notice.

On 10/12/18, 10/20/18 and 10/21/18 when the pills were found in the medication cart the pyxis was check to see if a waste was documented for the narcotics pills as required by the VA policy. The undocumented waste was noted in the pyxis on the dates above. The waste was cleared on another date."

Victim

Name: UNITED STATES GOVERNMENT
Gender: **Ethnicity:**
Status:
Driver's License: **State:** GENERAL
Work Address: N/A
N/A
N/A, US
Work Phone:
Treatment: No

Suspect

Name: (b) (6), (b) (7)(C)
SSN: [redacted]
Gender:
Weight:
Skin Tone
Status:
Driver's L
Home Add
Home Pho
Work Address: VA Hudson Valley health Care System
2094 Albany Post Rd.
Montrose NY 10548

Work Phone: (b) (6),

Facility: Hudson Valley HCS IR#: 2018-11-05-1155-4139

Offense(s): Non-Criminal: Information(F)

Violation(s):

Name: (b) (6), (b) (7)(C)
SSN:
Gender:
Weight:
Skin Tone
Status:
Driver's Li
Home Add

Home Pho

Work Address: VA Hudson Valley HCS
2094 Albany Post Road
Montrose NY

Work Phone:

Offense(s): Non-Criminal: Information(F)

Violation(s):

Witness

Name: Helen Ogaree
Work Address: VA HVHCS-Montrose
2094 Albany Post Rd
Montrose, NY 10548
Work Phone: 9147374400
Statement: "On the 10/12/18, I passed the 2nd med pass for the shift, and I found 2.5 mg (half tab 5 mg) in the pill cutter. Apparently, (b) (6), was the med nurse for night shift. I gave this to the acting Nurse manager after I looked into the pyxis and discovered that (b) (6), (b) has undocumented unwitnessed meds (oxycodone). On 20th Oct, Ms Euam found another half tab of Oxycodone in the Pill Cutter. I checked the pyxis and discovered that (b) (6), (b) had undocumented unwitnessed waste. Again on 21st Oct, Ms Cheryl White found another half tab of Oxycodone in the pill Cutter. I checked the pyxis it showed that (b) undocumented unwitnessed waste for Oxycodone. I saved the the pictures in my phone and locked the meds in the acting nurse manager's office because it was on a weekend."

Name: Da-Eun Euam
Work Address: VA Hudson Valley Health Care System
2094 Albany Post Rd.
Montrose, NY 10548
Work Phone: 9147374400
Statement: "On the day of Oct, 20th 2018, I was working on a day tour from 7:30 AM to 4:00 PM. I was checking my med cart to pull out medications for residents in meds room at approximately 8:15 AM. While I was checking bins in med cart, I noticed a pill on the pill-cutter from one of the bins. I called my charge nurse of the day - Helen Ogaree, who was standing near me at that time. From then, the charge nurse took the pill on the pill-cutter and put in a plastic bag."

Name:	Cheryl White
Work Address:	VA Hudson Valley Health Care System 2094 Albany Post Rd. Montrose, NY 10548
Work Phone:	9147374400
Statement:	"On 10/21/2018 upon locking my cart, I parked it in a corner outside of the dayroom. I went over to check the suction machines or/and tend to something else inside of dayroom. Another individual (Helen Ogaree)CN went into my med cart. I was unaware. The person (Helen Ogaree)CN then came to me and made me aware they found (1/2) half of an Oxycodone tab in the cart. The individual then stated to me that they knew it was not mine and did not belong to me because it was morning and I did not pull this particular medication as of yet. The pill was from the previous shift 12m - 8am. This particular pill is pulled on the day shift in the afternoon. The person that I had this conversation with was the charge nurse for that tour, Helen Ogaree."

Narrative

Origin

Chief PACK directed that an officer respond to Ward 6CD and meet with the Nurse Manager regarding a series of Pyxis machine discrepancies involving narcotic medication. I was assigned this case for investigation.

Initial Observation

I arrived on Ward 6CD and observed Nurse Manager Rose RUBIN seated in her office, room 269.

Investigation

On Monday, November 5, 2018 at 1155 hours, I was assigned a complaint by Nursing Service staff that Ward 6CD Charge Rose RUBIN had discovered a pattern of irregularities involving the dispensing of Oxycodone narcotic pain medication from the Ward 6CD medication room, and in particular, the potential for diversion during the Oxycodone wasting procedure.

At 1235 hours, I arrived at room 269, the office of Ward 6CD Nurse Manager Rose RUBIN. RUBIN advised me that she had discovered a pattern of three separate incidents, each on separate days, in which Ward 6CD LPN (b) (6), (b) (7) had reported that she "wasted" narcotic medication (Oxycodone IR narcotics tablet halfs), but each time the supposedly wasted tablet half of Oxycodone IR medication was discovered inside a pill cutter in the ward medication room.

RUBIN explained that the term "waste," or "wasted" when related to dispensing medication from the Pyxis machine refers to the process by which the dispensing LPN or RN must dispose of medication in excess of the patients required dosage. All three of these incidents involve (b) (6), (b) (7)(C) dispensing medication to Ward 6CD patient (b) (6), (b) (7) . Because (b) (6), is prescribed 2.5 mg of Oxycodone twice daily (morning and afternoon), and the smallest manufactured dosage of Oxycodone IR available is a 5 mg tablet, (must use a pill cutter equipped in every medication cart to cut the tablet in half. Once the 5 mg tablet is cut in half, one 2.5 mg half of the 5 mg Oxycodone IR tablet is administered to the patient, and the remaining 2.5 mg half is required to be wasted. RUBIN explained that it is mandatory to have another RN witness an LPN wasting medication, and to record the witnessing RN's name in the Pyxis Machine waste entry.

Wasted medication is required to be disposed of in the Med Room "Cactus Box", so named because the green plastic box has a raised plastic cactus tree logo on the front of the box. The locked Cactus Box is mounted approximate 5" high on the wall in the Ward 6CD Med Room. The lid has three openings. The first hole on the left is approximately 2" in diameter is used to deposit or "waste" solid medications such as pills and tablets, the second opening near the middle of the lid is used to waste prescription patches and has a 3" long slot with a wedge stored in the slot and used to push the patches through the slot, and the last opening being a 4" diameter hole on the lid tapering down to a 2" hole with a plastic screen through which liquid medication is poured/wasted.

The first incident occurred on Friday, 10/12/2018. At 06:21:30 hours (b) (6), (b) (7) recorded in the Pyxis Machine that she removed one 5 mg pill of Oxycodone IR of which half of the pill, or 2.5 mg was administered to Ward 6CD patient (b) (6), (b) (7) . At approximately 1100 hours that date Charge Nurse Helen OGAREE was in the Medication Room checking the medication cart when she discovered a 2.5 mg half Oxycodone IR pill inside the pill cutter in the Med Cart. OGAREE checked the Pyxis machine database and determined that (b) , the night shift medication nurse had removed one 5 mg Oxycodone IR pill at 0621 hours. OGAREE noted that ward patient (b) (6), (b) (7) was the only patient receiving prescribed Oxycodone IR

medication, and that the Pyxis machine showed that 2.5 mg of Oxycodone IR had been administered to (b) (6), by (b) (6), (b) (7), but there was no entry for the wasting of the remaining 2.5 mg half Oxycodone IR pill. CN OGAREE determined that (b) (6), (b) (7) had left the half Oxycodone pill in the pill cutter. OGAREE notified Rose RUBIN, the acting Nurse Manager of Ward 6CD, and gave the Oxycodone pill half to RUBIN who wasted the pill half in the Cactus box.

The second incident occurred on Saturday, 10/20/2018. At 06:41:31 hours (b) (6), (b) (7) recorded in the Pyxis machine that she removed one 5 mg Oxycodone IR pill of which half of the pill, or 2.5 mg was administered to Ward 6CD patient Steven (b) (6), . At approximately 0815 hours, RN Da-Eun EUAM was in the Medication Room preparing to draw morning medications for Ward 6CD patients, when she discovered one half Oxycodone IR pill (2.5 gm) inside the pill cutter in the Med Cart. RN EUAM notified Ward 6CD Charge Nurse OGAREE of the found half pill. OGAREE took possession of the half pill and placed it inside a small plastic bag. OGAREE checked the Pyxis machine database and determined that (b) (6), (b) (7) had removed the 5 mg Oxycodone IR pill, administered one half or 2.5 mg of the pill to patient (b) (6), but had failed to document the wasting of the second half of the pill.

The third incident occurred on Sunday, 10/21/2018. At 06:18:48 hours (b) (6), (b) (7)(C) in the Pyxis machine that she removed one 5 mg pill of Oxycodone IR of which half of the pill, or 2.5 mg, was administered to Ward 6CD patient (b) (6), (b) (7) . Later that morning CN Helen OGAREE and LPN Cheryl WHITE found another 2.5 mg half Oxycodone IR pill inside the pill cutter in the Med Cart. RN OGAREE placed the tablet in a small clear plastic bag. OGAREE checked the Pyxis machine database and determined that (b) (6), (b) (7) had removed the 5 mg Oxycodone IR pill, administered one half or 2.5 mg of the pill to patient (b) (6), but had failed to document the wasting of the second half of the pill. OGAREE locked both half pills, each in their own small clear plastic bag, inside Nurse Manager RUBIN's desk inside her locked office.

Nurse Manager RUBIN advised me that on October 13, one day later (b) (6), (b) (7) made a Pyxis machine wasting entry for the 2.5 mg half Oxycodone IR pill from the 5 mg pill she removed on October 12, and listed (b) (6), (b) (7)(C) as a witness to that wasting. RUBIN also advised that several days after the October 20 and 21 removals of Oxycodone IR 5 mg pills, (b) (6), (b) (7) made wasting entries for the 2.5 mg half pills from each of those dates. (listed (b) (6), (b) (7)(C) as the RN who witnessed (b) (6), (b) wasting of the October 20 and 21 2.5 mg half Oxycodone IR pills. RUBIN believes that (b) (6), went back to the Pyxis machine and made delayed entries indicating the wasting of the 10/20 and 10/21 Oxycodone IR 2.5 mg half pills after the pills had already been recovered (by RN EUAM and CN OGAREE/LPN WHITE), each time from the pill cutter in the ward medication cart. NM RUBIN advised me that a pharmacy technicion picked up the two 2.5 mg half Oxycodone IR pills which were recovered on October 20 and 21 from the pill cutter in the medication cart, and took them back to the pharmacy where they are currently locked inside the pharmacy vault.

On Tuesday, November 6, 2018, I interviewed RN Da-Eun EUAM in room 269 of Ward 6CD. RN EUAM completed a Memorandum: Statement of Understanding, and wrote out a Voluntary Witness Statement detailing her discovery of the 2.5 mg half Oxycodone IR pill she discovered in the med cart pill cutter, and her notification to CN OGAREE of the discovered half pill. Both the memorandum and voluntary witness statement are attached to this report.

On Wednesday, November 14, I interviewed CN Helen OGAREE in room 269 of Ward 6CD. CN OGAREE completed a Memorandum: Statement of Understanding, and wrote out a Voluntary Witness Statement detailing her discovery of the 2.5 mg half Oxycodone IR pill she discovered in the med cart pill cutter, and her notification to NM RUBIN of the discovered half pill. Both the memorandum and voluntary witness statement are attached to this report.

On Wednesday, November 21, at approximately 0030 hours, PO ARIUS obtained a Memorandum: Statement of Understanding, and a Voluntary Witness Statement from LPN Cheryl WHITE in the Nurses Station of Ward 6CD. LPN WHITE detailed how CN Helen OGAREE discovered a 2.5 mg half Oxycodone IR pill in WHITEs med cart pill cutter, and notified WHITE of the discovery. Both the memorandum and voluntary witness statement are attached to this report.

On Wednesday, November 21, at approximately 1300 hours I met with Pharmacy Manager Leonard

MANZELLA in his office in the pharmacy. I discussed the process of wasting medication on the wards. MANZELLA explained that the Pyxis Machine will not allow a wasting entry to be made without a fingerprint scan of the Medication Nurses (LPN or RN), and a fingerprint scan of a witnessing RN. MANZELLA stated that RNs witnessing the wasting of narcotic medication are required to physically be present at the Cactus Box, and must observe the wasting nurse deposit the narcotic medication being wasted into the locked Cactus Box. Nurses are required to waste narcotic medication as soon as possible after cutting. A Pyxis Machine entry must also be done at the time of wasting. MANZELLA stated that the best thing for medication nurses to do would be an "integrated waste" where the narcotic would be removed from the Pyxis Machine, and cut, and then any byproduct or residual narcotics wasted with witness immediately. MANZELLA stated that Nursing supervisors on the wards have to be more proactive in ensuring the entire medication process is done in accordance with established rules and procedures.

MANZELLA provided me with a Pharmacy Care Fusion software VA Hudson Valley All Device Events Narrative Report which documented all Pyxis Machine Narcotics Removals and Wastes for patient (b) (6), (b) (7) during the dates of October 12-13, and October 20-23. MANZELLA noted that Ward 6CD patient (b) is prescribed 2.5 mg Oxycodone IR (Immediate Release) twice daily (morning and afternoon). Because the pharmacy only stocks 5 mg Oxycodone IR pills, the medication nurse would remove one 5 mg Oxycodone IR pill from the Pyxis Machine, and then cut that pill in half in a pill cutter located in the medication cart. One 2.5 mg half Oxycodone IR pill would be dispensed to patient (b) (6), , and the remaining 2.5 mg half Oxycodone IR pill would be wasted in the locked Cactus Box, and an RN is required to witness the wasting. Both the Medication Nurse and the witnessing RN must be recorded by index finger scan in the Pyxis Machine. MANZELLA determined via the All Device Events Narrative Report that on Friday, October 12, 2018, at 06:21:30 hours (b) (6), (b) (7)(C) had removed one 5 mg OXYCODONE IR pill, to dispense one 2.5 mg half Oxycodone IR pill to patient (b) (6), . (b) (6), (b) id not enter the wasting of the remaining 2.5 mg half pill in the Pyxis Machine until the following day, Saturday, October 13, at 06:30:28, and (b) (6), (b) (6), (b) was the witnessing RN as reported by fingerprint scan. On Saturday October 20, at 06:24:31 hours, and again on Sunday, October 21, at 06:18:48 hours (b) (6), (b) (7) again removes on 5 mg Oxycodone pill each day to administer one 2.5 mg Oxycodone IR half pill to patient (b) (6), . MANZELLA noted that (did not make wasting entries for the October 20 and 21 removals in the Pyxis Machine until several days later.

On Monday, November 26, at 1415 hours, I interviewed (b) (6), (b) (7)(C) in room 5E of Police Operations (completed a Statement of Employee Rights and Obligation, a VA Form 1430 VA POLICE PRE QUESTIONING ADVICE OF CONSTITUTIONAL RIGHTS, a Memorandum: Statement of Understanding, and wrote out a VA Form 0023 Voluntary Statement - Waiver of Rights. All forms are attached to this report. My interview of (b) (6), (b) is detailed on the attached Follow Up Report.

On Tuesday, November 27, at 1700 hours, I interviewed (b) (6), (b) (7)(C) in room 5E of Police Operations. (completed a Statement of Employee Rights and Obligation, a VA Form 1430 VA POLICE PRE QUESTIONING ADVICE OF CONSTITUTIONAL RIGHTS, a Memorandum: Statement of Understanding, and wrote out a VA Form 0023 Voluntary Statement - Waiver of Rights. All forms are attached to this report. My interview of (b) (6), is detailed on a separate attached Follow Up Report.

This case involves two allegations. The first alleged there was the potential for possible diversion of narcotics taking place during the Oxycodone wasting procedure. (b) (6), (b) (7)(C) was identified as repeatedly having left 2.5 mg half Oxycodone IR pills in the medication cart pill cutter. Because these half pills were recovered by other nursing staff, I am unable to substantiate or confirm that any diversion took place. There is nothing to substantiate that any Oxycodone was diverted off of Ward 6CD. The three recovered 2.5 mg half Oxycodone pills were recovered from inside a pill cutting tool in a Ward 6CD medication cart. The pill cutter had been used to cut 5 mg Oxycodone pills in half to meet a Ward 6CD patient"s prescribed 2.5 mg Oxycodone dose. Because the Pharmacy does not inventory the Ward 6CD Cactus Box for a count of wasted 2.5 mg half Oxycodone pills, there is no way to determine if all of the 2.5 mg half Oxycodone pills listed as wasted in the Pyxis Machine were actually deposited into the locked Cactus Box, or if any are missing.

The second allegation in this case involves alleged violations of narcotic wasting procedures. I find grounds to support this allegation. I found that proper wasting procedures were not followed on each date, October 12, 20, and 21. In particular, the requirement that an RN actually witness the wasting nurse's deposit of 2.5 mg half

Oxycodone IR pills in to the medication room's locked Cactus Box were not adhered to in the interest of expediency during the busy daily pace of Ward 6CD activity. Some of the nurses may have allowed a so called Nurses Honor Code to lull them into complacency, by believing that they could trust another nurse when he/she stated he/she had already wasted a 2.5 mg half Oxycodone IR pill in the Cactus Box. (b) (6), (b) (7) admitted that she did not actually witness (b) (6), (b) (7) waste any medication on any of the three dates. Procedures which require a medication nurse to document narcotics wasting in the Pyxis Machine as soon as possible after wasting were not followed. (b) (6), (b) (7) was documented as having removed 5 mg Oxycodone pills in order to administer morning 2.5 mg half Oxycodone pills to patient (b) (6), . In the October 12 incident, (did not make the waste entry in the Pyxis Machine for the remaining 2.5 mg half Oxycodone pill of (b) (6), (b) morning medication until a day latter, and in the October 20 and 21 incidents, she waited several days to make the waste entries. In each of those three incidents nursing staff had already recovered the 2.5 mg half Oxycodone pills from the pill cutter in the medication cart, so what medication did (b) (6), claim to waste.

In her verbal answers, and on her written statement during my November 27 interview of (she states that she wasted the remaining 2.5 mg half Oxycodone IR pills after she dispensed patient (b) (6), (b) morning 2.5 mg half Oxycodone IR pill on October 12, 20, and 21. (stated she wasted the half pills and made the Pyxis Machine wasting entry prior to the end of her shift at 0800 on each of those three dates. I asked (b) (6), (b) if she was certain that she placed the remaining 2.5 mg half Oxycodone pill in the locked Cactus Box on each of those three dates and she stated she was certain that she did. I also asked (b) (6), if she was certain she made the Pyxis Machine waste entry on those same dates, October 12, 20, and 21, and she stated she was certain she did. (b) (6), (b) commented that while she was the medication nurse on each of those dates, all of the LPNs and RNs have the access code to unlock the medication cart at any time during those dates, as if to say that another Ward 6CD RN or LPN could have accessed the medication cart at any time.

At this time I do not find that a crime has been committed, and no charges are being contemplated with regard to (b) (6), (b) (7) and (b) (6), (b) (7) My belief is that fatigue from working nights, lackadaisical employee attitude toward medication documentation, the gradual erosion of nursing staff attention to policies, rules, and procedures, and a lack of Nursing Service supervisory oversight may have contributed to these events. Additional retraining and supervisory oversight might prevent this from recurring.

Investigating Officer: DAVID WARNER **Signature:** _____
Badge: 4440-ON **Date:** ___/___/_____
Printed by: RONALD ODELL

< < < End of Report > > >

Follow Up

Investigator: DAVID WARNER **Date/Time:** 11/26/2018 7:00:18PM

On Monday, November 26, 2018, at approximately 1415 hours, I interviewed (b) (6), in room 5E of Police Operations. (b) (6), (b) was accompanied by AFGE Local 1119 President Kim FREEMAN. I began the interview by providing (b) (6), (b) with a copy of the USDVA Police "Statement of Employee Rights and Obligation," otherwise know as Weingarten Rights. I advised (b) (6), (b) to read the statement, and print her name and sign her name if she understood her employee rights and obligations. (b) (6), (b) stated she understood her rights and obligations and signed the form. Kim FREEMAN and I signed the form as witnesses.

I then read to (b) (6), (b) VA Form 1430 VA POLICE PRE QUESTIONING ADVICE OF CONSTITUTIONAL RIGHTS. After reading to (b) (6), (b) her rights as listed on lines 1 through 7, I asked (b) (6), (b) if she understood her rights and (b) (6), (b) verbally answered yes, and she checked the Yes box and wrote her initials on line 8. I then asked (b) (6), (b) if she was willing to answer questions, and (b) (6), (b) verbally answered yes, and she checked the Yes box and wrote her initials on line 9. I then read the WAIVER OF RIGHTS statement on the back of the Form 1430 to (b), allowed her to read both sides of the form 1430, and then witnessed as (b) (6), (b) waived her rights and signed her name below the WAIVER OF RIGHTS statement.

I began my interview of (b) (6), (b) (7)(C) (b) (6), (b) (7)(C)

I explained to (b) (6), (b) that I was assigned an investigation into the possible diversion of, or attempts to divert, prescription pain medication occurring on Ward 6CD, and possible fraudulent Pyxis machine entries regarding prescription pain medication.

I asked (if she had any knowledge of any Ward 6CD Nursing staff involved in diverting prescription medication. (b) (6), (b) stated that she has never, in all her years working for the VA seen or heard of a VA Nurse diverting prescription pain medication. I asked (b) (6), (b) if she or any other nurse had taken any medication from the Pyxis machine or from the medication cart, or left any prescription pain medication, or remnants of prescription pain medication in the medication cart to be retrieved at a later time, and (b) (6), (b) stated she had never done such things, or heard of other nurses having done so.

I asked (b) (6), (b) if she had ever been asked to witness or participate in wasting medication where no medication was actually wasted. (b) (6), (b) began crying and stated that for a long time the nurses on Ward 6CD would ask another nurse to witness a wasting of prescription medication which the requesting nurse would tell the witnessing nurse she had already deposited the medication to be wasted in the Cactus box (b) (6), (b) stated there had always been an "Honor System" among nurses on the wards where a nurse would never ask another nurse to witness a wasting without the asking nurse having first disposed of the medication in the Cactus Box. I asked (b) (6), (b) if she recalled witnessing the wasting of medications for (b) (6), (b) (7)(C) on the dates of Friday, October 12, Saturday, October 20, and Sunday, October 21. (b) (6), (b) stated that she could not recall actual dates, but she has witnessed medication wasting for (b) (6), before. I asked (b) (6), (b) if she actually observed (deposit medication into the Cactus Box, and (b) (6), (b) admitted that she did not, but assumed that (did because of the Nurses "Honor System." (b) (6), (b) stated, "I did not see her waste anything. I made a poor decision. I never saw her wasting it, but she told me she wasted the medication. I always trusted the nurses I worked with."

Investigator: DAVID WARNER **Date/Time:** 11/28/2018 2:30:56PM

On Tuesday, November 27, 2018, at approximately 1700 hours, I interviewed (b) (6), (b) (7)(C) in room 5E of Police Operations. I began the interview by providing (b) (6), with a copy of the USDVA Police "Statement of Employee Rights and Obligation," otherwise know as Weingarten Rights. I asked (b) (6), if she wanted to have union representation present which she declined. I advised (b) (6), to read the statement, and print her name and sign her name if she understood her employee rights and obligations. (b) (6), stated she understood her rights and obligations and signed the form. I signed the form as a witness.

I then read to (VA Form 1430 VA POLICE PRE QUESTIONING ADVICE OF CONSTITUTIONAL RIGHTS. After reading to (b) (6), her rights as listed on lines 1 through 7, I asked (b) (6), if she understood her rights and (verbally answered yes, and she checked the Yes box and wrote her initials on line 8. I then asked (b) (6), if she was willing to answer questions, and (verbally answered yes, and she checked the Yes box and wrote her initials on Line 9. I read the WAIVER OF RIGHTS statement on the back of the Form 1430 to (b) (6), (b) allowed her to read both sides of the form 1430, and then witnessed as (b) (6), waived her rights and signed her name below the WAIVER OF RIGHTS statement.

I began my interview of (b) (6), (b) (7)(C) has been employed by the VA for (b) She is a Licensed Practical Nurse assigned to Ward 6CD. (b) (6), (b) (7)(C)

I explained to (b) (6), (b) that I was assigned an investigation into the possible diversion of, or attempts to divert, prescription pain medication occurring on Ward 6CD, and possible fraudulent Pyxis machine entries regarding prescription pain medication.

I asked (b) (6), (b) if she recalled if she was working on Friday October 12, Saturday October 20, and Sunday October 21 this year. (stated that she regularly works Fridays, Saturdays, and Sundays from 0001 to 0800 hours. I asked (if she was assigned as the Medication Nurse during those shifts, and she stated she was. I asked (b) (6), if she recalled removing Oxycodone medication from the Pyxis machine on each of those dates, and (stated that a Ward 6CD patient is prescribed 2.5mg of OXYCODONE each morning, and she removes a 5mg Oxycodone pill from the Pyxis machine early each morning. I asked how (b) (6), converts a 5mg Oxycodone pill into a 2.5mg dose for the patient each day. (stated that she cuts the 5mg pill in half, and gives the patient one 2.5mg halve of the Oxycodone pill. I asked (b) (6), how does she cut the Oxycodone pill in half, and she stated she used the pill cutter from the medication cart. I asked (b) (6), what did she do with the remaining halve of the Oxycodone pill, and she stated she threw the remaining halve in the "Biohazard Box." I asked (b) (6), what was she referring to when she stated "Biohazard Box" and she said the "box on the wall in the medication room." I showed (b) (6), a photo of the Cactus Box which is mounted to the wall in the Ward 6CD medication room, and asked her if that was the box she referred to as the Biohazard Box, and she said that was the Biohazard Box.

I asked (if she remembered doing this same process on each of the three dates, and she stated yes, she did the same process each day. I asked (b) (6), (b) if she was certain she wasted the remaining halve of the patient"s Oxycodone pills on those three dates, and she stated she was certain that she always wastes the remaining Oxycodone pill halves.

I asked (b) (6), (b) when did she waste the Oxycodone pill halves, was it the same day as the date she removed the 5mg Oxycodone pills from the Pyxis Machine. (stated she always wasted the same day as the date she removed the Oxycodone pills from the Pyxis Machine. I asked (b) (6), if it was possible that she forgot to waste the pill halve on occasion, but (b) (6), (b) maintained that she always wasted the remaining Oxycodone pill halves on the same date as tshe removed the pill from the Pyxis Machine.

I asked (b) (6), (b) if she made the wasting entries in the Pyxis Machine on the same dates (October 12, 20, and 21) as the day she wasted the Oxycodone pill halve. (stated she wasted the Oxycodone pill halves and made the wasting entries in the Pyxis Macine on the same date as the date she removed the pills from the Pyxis Machine. (b) (6), stated her wasting entries in the Pyxis were always done before the end of her tour of duty.

I asked (if she is required to have a Registered Nurse witness her wasting, or disposal of the the remaining halve of the Oxycodone pill in the Cactus Box, or Biohazard Box as she referred to the Cactus Box. (b) (6), stated she is required to have an RN witness all of her disposals of the halve Oxycodone pills. I asked (if the RNs which

witness her waste the Oxycodone halves are present by the Cactus Box, and are able to see her depositing the pill halves into the Cactus Box, and she stated that the witnesses always see her deposit the Oxycodone pill halves in the Cactus boxc

I asked (b) (6), if she remembered which RN she asked to witness her wasting or disposal of the halve Oxycodone pils on October 12, 20, and 21. [redacted] stated she could not remember which RN she asked to witness her wasting the Oxycodone pill haves on those dates. (b) (6), stated the has proably asked all of the RNs on her shift to witness various wastings on one or more of the the many dates she has been working on Ward 6CD. I asked (b) (6), to try to remember the name or names of the RN or RNs who witnessed her wastings on those dates but she said she could not.

Investigator: PHILIP FARRELL **Date/Time:** 12/3/2018 8:09:20AM

This report has been reviewed by a supervisor. No further Police action at this time. This report is closed to file.

Department of Veterans Affairs
VA Police
Hudson Valley HCS
Investigative Report
Investigative Report#: 2018-09-11-0908-4919

VA Facility: Hudson Valley HCS **Date/Time Printed** 6/6/2019 11:02

Date/Time Received	9/11/18 09:08 AM
Date/Time of Offense:	8/9/18 02:54 AM
Location:	Bldg. 3 Urgent Care
Investigating Officer	ANTHONY LUCIANO
Incident Synopsis:	HV Controlled Substance Inspection Coordinator advises Police Investigations of a loss/Theft of Class IV Narcotic Lorazepam 2mg 1 ml Injectable Investigation initiated. Investigation on going.
Classification Code:	Larceny - Theft Actual Drug Theft - Controlled Substance(F)
Final Disposition:	**Referral Accepted by VA-OIG**
Initial Disposition:	Initial Investigation Completed
Case Status:	CLOSED

Use of Force

OC Weapon used:	No
Baton Used:	No
Firearm Drawn:	No
Firearm Used:	No

Complainant

Name:	Michael Kelly
Status:	
Work Address	
Work Phone	
Statement	

Victim

Name:	UNITED STATES GOVERNMENT
Gender:	**Ethnicity:**
Status:	
Driver's License:	**State:** GENERAL
Work Address:	N/A N/A N/A, US
Work Phone:	
Treatment:	No

Suspect

Name:	(b) (6), (b) (7)(C)
SSN:	
Gender:	
Weight:	

Facility: (b) (6), (b) (7)(C) HCS IR#: 2018-09-11-0908-4919

Skin Tone: **Mark:**

Status:

Driver's License Number: (b) (6), (b) (7)(C) **License State:**

Home Address:

Home Phone:

Work Address:

Work Phone:

Offense(s): Larceny - Theft: Actual Drug Theft - Controlled Substance(F)

Violation(s):

Witness

Name: Larry White
Work Address: VA Hudson Valley Health Care System
2094 Albany Post Rd.
Montrose, NY 10548
Work Phone: 9147374400
Statement:

Name: Jose Martir
Work Address: VAHVHCS
Castle Point, NY 12511
Work Phone: 8458312000
Statement:

Name: Angela Douglas-Wallace
Work Address: VA HUDSON VALLEY HCS
2094 ALBANY POST ROAD
MONTROSE, NY 10548
Work Phone: 8458312000
Statement:

Name: Xuan Thao Thi Eastman
Work Address:
Work Phone:
Statement:

Property Lost

Item Name: LORAZEPAM
Description: (1) Lorazepam 2mg / 1 ml INJ.

Owner: Government
Dollar Loss: $ 0.35
Dollar Recovered: $ -

Notification

Facility:	Hudson Valley HCS	IR#:	2018-09-11-0908-4919

Agency:	VAOIG
Contact:	SA DANIEL CLARK
Date & Time of Notification:	9/11/18 1233
Instructions Received:	..

Narrative

Origin	9/11/2018 @ 0908, Michael Kelly, C.S. Inspection Coordinator at Investigations to report loss / Theft of C.S. Lorazepam 2mg / 1 ml Inj from Urgent Care. Identified during a routine C.S. Inspection.
Initial Observation	Document showing removal and inventory of said medication. Along with medical Record Review form for C.S. Inspection.
Investigation	09/11/2018, Michael Kelly at Investigations reporting that on 08/29/2018, a C.S. Inspector, Larry White, assigned by Kelly to review All Station Events records for discrepancies, identified that on 08/09/2018 a removal of Lorazepam 2mg / 1ml Injectable was conducted by RN ANGELA DOUGLAS-WALLACE in the Montrose Urgent Care. Lorazepam was then given to (b) (6), (b) (7)(C) [redacted] of 6 C/D for administering to patient [redacted] upon reviewing patient records, M. Kelly identified that no record was documented of the actual dispensing of the medical. Further check of the record identified that on the same date at 1935 hours, RN XUAN THAO EASTMAN conducted an inventory which was witnessed by NICHELLE LAWRENCE, which still identified the removal was conducted. Further more, a review of the patients progress notes failed to identify the administering of the medication for that day. On 9/11/2018, the patient record still failed to identify the medication being administered. M/ Kelly stated that after communication with Charge Nurse ROSE, 6 C/D, he was advised that the medication was administered to the patient. Contact with Pharmacist LENNY MANZELLA, for dollar amount of the Lorazepam 2mg/ 1 ml injectable was conducted and identified the amount of loss/ Theft was

Investigating Officer:	ANTHONY LUCIANO	**Signature:**	_____
Badge:	1528-IN	**Date:**	___/___/_____
Printed by:	RONALD ODELL		

< < < End of Report > > >

Follow Up

Investigator: BRIAN PACK **Date/Time:** 1/14/2019 11:50:00AM

01/14/19;

Please will be listed as closed pending additional follow-up the Manhattan VA OIG office.

Department of Veterans Affairs
VA Police
Hudson Valley HCS
Investigative Report
Investigative Report#: 2018-07-27-1706-7329

VA Facility: Hudson Valley HCS **Date/Time Printed** 6/6/2019 11:03

Date/Time Received	7/27/18 17:06 PM
Date/Time of Offense:	7/26/18 09:30 AM
Location:	Building 4 Pharmacy
Investigating Officer	ANTHONY LUCIANO
Incident Synopsis:	Pharmacy Supervisor reports during a Controlled Substance count , pharmacy was short (30) Hydrocodone 10mg/APAP 325mg tablets. Police reviewing surveillance cameras for pharmacy vault. Investigation on going.
Classification Code:	Larceny - Theft Actual Drug Theft - Controlled Substance(F)
Final Disposition:	**Case Closed**
Initial Disposition:	Initial Investigation Completed
Case Status:	CLOSED

Use of Force

OC Weapon used:	No
Baton Used:	No
Firearm Drawn:	No
Firearm Used:	No

Complainant

Name:	Leonard J Manzella
Status:	Employee - Admin
Work Address	2094 Albany Post Road Building 4, Pharmacy Montrose, NY 10548
Work Phone	9147374400
Statement	

Victim

Name:	UNITED STATES GOVERNMENT
Gender:	**Ethnicity:**
Status:	
Driver's License:	**State:** GENERAL
Work Address:	N/A N/A N/A, US
Work Phone:	
Treatment:	No

Suspect

Name:	(b) (6), (b) (7)(C)
SSN:	
Gender:	
Weight:	

Facility: Hudson Valley HCS IR#: 2018-07-27-1706-7329

Skin Tone (b) (6), (b) (7)(C)
Status:
Driver's Li **License State:** (b)
Home Adc
Home Pho
Work Address: VA Hudson Valley HCS
2094 Albany Post Road
Montrose NY 10548

Work Phone: (b) (6),
Offense(s): Larceny - Theft: Actual Drug Theft - Controlled Substance(F)

Violation(s):

Witness

Name: (b) (6), (b) (7)
Work Address:

Work Phone:
Statement: .confirmed double dispensing o medications. Will bring extra back to Montrose.

Property Lost

Item Name: hydrocodone
Description: (30) Hydrocodone tablets @ .08 cents/tab.

Owner: Government
Dollar Loss: $ 2.40
Dollar Recovered: $ 2.40

Notification

Agency: VAOIG
Contact: RAC CHRISTOPHER WAGNER
Date & Time of Notification: 7/31/18 0930
Instructions Received: ..

Narrative

Origin
7/27/2018 @ 4:30 PM, Pharmacy Supervisor L. Manzella email reported the loss of (30) Hydrocodone tablets from Pharmacy Vault.

Initial Observation
Manzella email states that the possibility of when pharmacist was filling prescription he may have inadvertently double filled bottle. Review of camera surveillance being conducted.

Investigation
After review of camera surveillance it was determined with assistance of A/C Romeo and Supervisor Manzella that pharmacist on duty did in fact double fill a bottle. Manzella was waiting for a return call from Veteran (b) to verify that was in fact the issue.
07/31/2018, Pharmacy Supervisor Manzella made notification to Police confirming contact with veteran who stated he did receive double on the prescription count and would be stopping at pharmacy to return medication overage.
This case is closed by investigation to be reviewed by Pharmacy Administration for re education of the handling of dispensing medications.

DISPOSITION:

Case closed by investigation.

Investigating Officer: ANTHONY LUCIANO **Signature:** _____
Badge: 1528-IN **Date:** ____/____/_____
Printed by: RONALD ODELL

< < < End of Report > > >